STATE TITLE V BLOCK GRANT NARRATIVE
STATE: RI
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and certifications are maintained on file c/o Cheryl LeClair, Rhode Island Department of Health, Division of Family Health, Room 302, 3 Capitol Hill, Providence, Rhode Island 02908. (Phone: 401-222-4636; email: cheryll@doh.state.ri.us)

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

/2006/ The DFH solicited feedback from a variety of key stakeholders and families on the MCH needs of its target populations and on MCH programs and services through a variety of forums throughout FY2006. Over the past year, these forums have included WIC, adolescent health discussions, focus groups, individual consumer input (including PRAMS), and a formal Title V MCH public hearing held on June 7, 2005. In addition, input obtained through the Family Planning Program's annual community input process provides valuable information about the family planning needs of Rhode Islanders of reproductive health age.

The Title V MCH public hearing was publicized through extensive mailings to community agencies and other key stakeholders and through a formal legal notice in the state's single statewide newspaper, the Providence Journal. Over 50 individuals attended the public hearing and the DFH obtained input from an additional 250 individuals attending a variety of specific meetings. In addition, the Family Planning Program received completed community input surveys from 72 health care providers, Title X family planning staff, social service providers, advocacy organizations, and teens.

Common themes among these sources have emerged and the following represents a summary of the issues and ideas that were raised this year for the FY2006 plan (see attachment) //2006//.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The state of Rhode Island is a small (1,055 square miles), coastal area of just over one million residents (1,048,319). The entire state measures just 48 miles, from north to south, and 37 miles, from east to west. Historically, most Rhode Islanders have been White (82%) descendants of European immigrants, plus some long established African American families and members of the small Narragansett Native American Indian Tribe.

With the establishment of the first water-powered cotton mill in the nation in Pawtucket in 1793, Rhode Island became the birthplace of the industrial revolution in the United States. Since then, waves of immigrants -- from Italians and Irish in the late 19th century to Asians and Latinos in the late 20th century -- have come to Rhode Island in search of a better life. Currently, an estimated one in eight Rhode Islanders is foreign-born, making the state home to the highest number of immigrants per capita in the country.

Eighty-six percent (86%) of Rhode Island's population resides in urban areas, which ranks the state seventh "most urban" and second most densely populated state in the nation after New Jersey, with 1,003 residents per square mile. In this small state - cities, suburbs, and "rural" areas are separated in some places by only a few miles of road. Even the most "remote" parts of the state are less than an hour's drive from the state's capitol city of Providence. With over 400 miles of coastline and a wealth of historical resources, Rhode Island is an attractive place to work and live. Rhode Island's economy is built on three major industries: health services, tourism, and manufacturing.

As with other urban centers in the northeast, Rhode Island remains an important hub of government, health care, education, and entertainment activity, but faces the many challenges that its increasingly diverse and aging infrastructure present. Although two-thirds of the state is relatively "rural" in character, most of its population is concentrated in the urban, northeastern part of the state, around Providence. Providence is a major metropolitan community in which more than 173,000 residents live. An additional 437,349 residents live in the ten urban and "suburban" urban communities surrounding Providence.

Rhode Island has advantages for effective public health program implementation, given its small geographical size and unique governmental structure. With the exception of the state court system, there is no county level of government in Rhode Island. The state is made up of 39 cities and towns ranging from 1.3 to 64.8 square miles in size. In Rhode Island, local communities possess control in areas such as primary and secondary education, subdivision of land and zoning, and housing code enforcement. A combination of cultural, socio-economic, and transportation-related factors makes "the neighborhood" the most important level of community in Rhode Island, especially for low-income residents.

The sole public health authority in the state is the Rhode Island Department of Health (HEALTH), which makes it legally responsible for the provision of core public health activities on both the state and local levels. Unlike many other states, HEALTH contracts with community-based organizations and professionals to provide nearly all direct preventive and public health services. HEALTH has no public health clinics. The absence of local health authorities means that health care providers in the state look to HEALTH for policy guidance and other forms of assistance.

Population Characteristics

About one fifth of the state's population (204,380) is women of childbearing age (15-44 years). Like other areas in the nation, Rhode Island has an aging population. According to the 2000 Census, the median age for female residents in Rhode Island is now 38 years. However, the median age for females varies by race and ethnicity. The median age for White female residents is 40.1 years. In contrast, the median age for female residents belonging to a racial or ethnic minority group is as follows: Hispanics (24.6 years), Blacks (27.6 years), Asians (26.8 years), and Native American (28.4

years). ***//2006// Women of color currently make up about 28% of the female population in Rhode Island.***

On the positive side, women in Rhode Island have the highest levels of health insurance coverage (94% verses 83.4%) and the lowest levels or mortality from suicide (2.8 verse 4.4 per 100,000) as well as among the highest median annual earnings in the nation ($29,600 verse $26,900). On the negative side, Rhode Island women have among the worst mortality rates in the nation from heart disease (179.6 verses 161.7 per 100,000), lung cancer (46.5 verses 41.3 per 100,000), and breast cancer (31.5 verses 28.8 per 100,000). These poor markings might be related to the fact that women in Rhode Island engage in relatively poor health habits -- the percentages who smoke (23% verses 21.2%), binge drink (9.1% verse 6.7%) and do not engage in leisure time physical activity (30.6% verses 28.6%) are all higher than in the nation as a whole.

Women in Rhode Island are much less likely to have some college than women in the United States, at 21.5% and 25%, respectively. In addition, the proportion of women older than 25 in Rhode Island without high school diplomas is much larger than that of women in the United States (28.7% and 25.2%, respectively). In 2000, nearly one out of three Hispanic girls dropped out of Rhode Island's high school schools. Single women with children in Rhode Island have a higher poverty rate than single women with children in the nation (37.9% verse 35.7%) //2006//.

Each year, Rhode Island's women deliver about 12,500 new babies in Rhode Island and, currently, about one quarter of the state's population is made up of children under 18 years old (247,822). A major finding from the 2000 Census was the overall increase in the number of children under age 18 in Rhode Island and nationally. In Rhode Island, the child population increased 9.8% in the 1990s. The largest increase (20%) in any age category was in the number of children in early adolescence (ages 10-14). In contrast, the number of children under age 5 living in the state dropped nearly 5%.

Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. 73% of Rhode Island's children are White, 5% are African American, 3% are Asian, 1% is Native American, 1% is some other race, and 3% are more than one race. 14% are of Hispanic/Latino ethnicity. Due to both increased immigration and increased birth rates, it is expected that between 1997 and 2005 the number of Hispanic children in Rhode Island will increase by 52% and the number of Asian children by 75%.

/2004/ In 2000, 17%, or 40,117, Rhode Island children were living in poverty //2004//. This is an increase from the 1990 Census figure when 14% of the state's children lived in poverty. In addition, Rhode Island has one of the highest rates of single-parent families in the nation, and the highest rate in New England. /2004/ In Rhode Island, the percentage of births to unmarried mothers has increased from 26% in 1990 to 36% in 2000. Rhode Island is ranked 11th in the country for the highest rates of births to unmarried mothers //2004//.

Thirty percent (30%) of children in Rhode Island (67,978) and 47.8% of children living in the state's core cities (38,706) live in a single-parent family. Eighty-three percent (83%) of children living below poverty in Rhode Island live with a single mother. White children and Asian children are far more likely to live in married-couple families than are Black and Hispanic children. Almost 61% (60.6%) of Black children and 52.9% of Hispanic children in the state-live in single-parent families.

During the 1990s, the state gained about 82,500 racial and ethnic minorities, slightly more than half of them Hispanics. ***/2006/ Forty-three percent of Rhode Island's population growth involved individuals with limited English proficiency. The national rate was 14% //2006//***. Immigration grew substantially in Rhode Island (and in the nation) during the 1990s. For the period 1990-1994, about 6,000 individuals immigrated to Rhode Island. In 1999, Rhode Island was home to 87,559 foreign-born residents. Of these, 6,798 were under 18 years of age, 3% of all children in the state. ***/2006/ The U.S. Department of Homeland Security estimates that, in 2000, there were 16,000 undocumented individuals living in Rhode Island //2006//***.

/2006/ Federal immigration statistics show that the largest groups of immigrants to Rhode Island in 2000 were from the Dominican Republic (18.3%), Cape Verde (10.2%), Guatemala (9.1%), Columbia (8.9%), Liberia (5%), and Portugal (4.3%). Together, these groups make up more than half (55.8%) of all individuals who immigrated to Rhode Island in 2000 //2006//. For the first time in history, Rhode Island has communities (Providence and Central Falls) where minorities outnumber non-Hispanic Whites.
/2006/ Although only 6% of all public school students in Rhode Island were English language learners during the 2002/2003 school year, 30% of all Central Falls public school students, 19% of all Providence public school students, and 12% of all Pawtucket public school students were English language learners during this same period. The primary language for 73% of Rhode Island's English language learner students was Spanish, followed by Portuguese (6%), Cape Verdean (3%), and other (17%) //2006//.
According to the U.S. Census, the racial/ethnic distribution of Rhode Island's population in 2000 consists of Whites (85%), Blacks (4.5%), Asians (2.3%), Native Americans (0.5%), Native Hawaiian or Pacific Islander (0.1%) and those who identified themselves as being more than one race (7.6%). In the past ten years, Rhode Island's non-Hispanic White population declined by 4%. During the same period, the state's Black population increased by 21%, Asians by 31% and Native Americans by 26%.

Blacks represent the largest racial minority group (and the second largest minority group) in the state and they have been established in Rhode Island for many years. During the 1990s, the state's black population grew by 21%, to about 46,908 people. Rhode Island's black population became increasingly diverse during the 1990s as a result of increased immigration from Haiti, Cape Verde, Liberia, and Nigeria. Over 11% of Blacks in the state are Latino, a large majority of whom came from the Dominican Republic. Nearly 99% of Blacks in the state live in urban areas, mainly Providence, Woonsocket, Pawtucket, Newport, or East Providence.

Asians grew by 31% during the 1990s and Cambodians, Hmong, Laotians, Thai, and Vietnamese represent 44% of the state's Asian grouping. Most Southeast Asians immigrated to Rhode Island from the war-torn countries of Vietnam, Cambodia, and Thailand during the 1970s and 1980s. From 1975-1979, well-educated professionals escaped from Cambodia and after a brief stay in Thai refugee camps, were resettled in the United States (including in Rhode Island) and Canada. From 1975-1985, well-educated Cambodians continued to resettle, and larger numbers of rural agrarian families arrived in the United States, including Rhode Island. About 93% of Asians in Rhode Island live in the older, urban communities or Providence, Woonsocket, and Cranston.

Native Americans grew by 26% during the 1990s and they consist primarily of members of the Narragansett Indian Tribe. Most Native Americans live in Providence, Narragansett, North Kingstown, and Charlestown. The Narragansett Reservation near Charlestown currently has about 2,500 acres, on which about 2,500 people reside. The actual number of Native Americans living in Rhode Island remains very small (5,241). The Narragansetts are governed under the traditional leadership of a Chief Sachem with a nine-member sovereign Tribal Council.

However, more striking than any other trend was the surge in the number of Latinos in the state. Latinos saw their numbers double in Rhode Island in the 1990s from 45,572 to 90,820, a pace double that found in Massachusetts. /2004/ Of this number (90,820), 35,000 are children //2004//. Latinos now make up 8.7% of the state's population. Most of Rhode Island's Latino growth occurred in Providence, Pawtucket, and Central Falls. Latino students now make up about 47% of the school population in Providence. Although there are small groups of Latinos living in just about every community in the state, four out of five are concentrated in the older, urban communities of Providence, Pawtucket, Central Falls, Woonsocket, and Cranston. ***/2006/ The majority of Latinos in Rhode Island (63.9%) come from Puerto Rico (28%), the Dominican Republic (19.7%), Guatemala (9.9%), and Columbia (6.3%) //2006//***.

Rhode Island's population grew by 44,855 to 1,048,319 between 1990 and 2000, which represents a 4.5% increase. This growth was entirely attributable to minorities. The state lost nearly 38,000 Non-Hispanic Whites during the 1990s, as an elderly generation of mostly White residents died and as

young professionals crossed state lines in search of better jobs. At the same time, the state gained about 32,500 racial and ethnic minorities, slightly more than half of them Hispanics. In 1990, one in ten Rhode Islanders belonged to a racial or ethnic minority group. In 2000, nearly one in five did.

Rhode Island will continue to become more ethnically and racially diverse during this century. The state's racial and ethnic minority populations are undergoing a very rapid growth rate, especially in the state's urban, core communities. According to Census 2000 projections, African Americans in Rhode Island will increase by 38%, Asians by 55% and Hispanics by 65%. Between 1995 and 2005, the number of White, Non-Hispanic children is expected to decrease by 7%, while the number of Black, Hispanic, Asian, and Native American children will increase by 43%.

In Rhode Island, the health disparities experienced by the poor and racial and ethnic minorities have been well documented. In general, Rhode Island's racial and ethnic minorities are more likely to be poor, uninsured for health care, unemployed, and have limited access to quality, affordable housing. Racial and ethnic health disparities in Rhode Island are discussed in more detail in the need assessment section of this application.

State Issues Impacting Women & Children

In earlier generations, Rhode Island workers were well-paid and well-insured for health care through the presence of a strong manufacturing base. However, many manufacturing jobs were lost in recent decades, and in the 1990s, Rhode Island experienced its worst recession since the Great Depression in the 1930s, losing 11.6% of its total job base and seeing 10% unemployment rates. After weathering the financial storms that battered the state in the early 1990s, Rhode Island rode a wave of economic growth in mid-1990s that few could have envisioned.

Taking advantage of a strong economy, the state was able to reduce taxes, increase state spending by double and triple the rate of inflation, and still realize $100 million end-of the year surpluses. Since 1996, the state increased support for public schools by 47.1%, expanded medical insurance programs for needy Rhode Islanders by 206.7%, and strengthened capital spending by 262.9%. /2004/ In the early 2000s, the state's (and the nation's) economic cycle reversed again. Although many economists believe that the national recession has ended, the ensuing recovery continues to struggle to regain its footing and, as a result, the national recovery was likely to be " jobless", through at least the first half of 2003.

On a comparative basis, Rhode Island's economy has fared well and Rhode Island's economic performance has outpaced those of Connecticut, Massachusetts, and the nation as a whole. The restructuring of the state's economy during the 1990s has been given as one of the reasons for its resilience. Although many economists believe that the national recession has ended, they are also predicting a slow recovery. ***/2006/ Last year, Rhode Island employers added about 1,000 jobs, an increase of 1%. The national job growth rate last year was 1.5%. However, the state unemployment rate remained unchanged at 4.4%. Nationally, the jobless rate is 5.4%. In addition, oil hit a high price of $57.50 per barrel before retreating slightly in March of 2005. Some economists believe that high-energy prices may hurt economic growth and stoke inflation, prompting a possible rise in mortgage rates.***

In addition, the sustained high price of home heating oil (about $2.00 per gallon) during made the 2004 the most expensive winter for oil users in the state in at least 15 years. A household that burned 1,000 gallons of home heating oil during the winter, buying at the state average price, would have paid $2,017 for heat during the winter of 2004. That is 31%, or $473, more than last year. About 42% of Rhode Island's households heat with oil.

The Governor's FY2006 $6.2 billion budget proposal avoids broad based tax increases and relies on cost cutting opportunities to close a project $165 million deficit. With respect to health and human services, the Governor is pushing for the authority to remove families from state welfare rolls after a year if parents do not carry through on their employment and job

training plans. Applicants would also have to complete and employment plan before they could get their first welfare check.

A family of three on RIte Care earning between $23,505 and $28,990 a year would go from paying 6% to 8% of its income on premiums; their weekly bills climbing from an average of $30 to $40. A similar family earning up to $35,258 per year would pay up to 16% of their income; its average weekly bills would rise from $89 to $102. If a child on RIte Care shows up in an emergency room with a primary care problem, Rite Care will pay only the $40 or so it pays for a doctor's visit, instead of the $250 to $350 emergency room cost. The Governor is also seeking larger co-payments from many families with children in state-subsidized childcare//2006//.

Secure parental employment is a strong determinant of whether or not children will be poor. ***/2006/ In Rhode Island in 2000, there were about 52,043 children with no parent working full time, year round. This is almost one-quarter of all children in the state //2006//***. The level of secure parental employment varies by race and ethnicity in Rhode Island. /2004/ In 2000, 69% of Black, Non-Hispanic children and 72% of Hispanic children had a parent working full-time, full-year in contrast with 85% of White, Non-Hispanic children //2004//. /2005/ Between 1983 and 2000, Rhode Island lost 93,000 jobs for adults with a high school diploma and gained 89,000 for adults with at least some college education. This shift in labor demand will continue to have a huge impact on wages as well as implications for moving families out of poverty //2005//.

In addition to good jobs for parents, safe, quality, affordable housing is also a basic issue for family health, and a challenge in Rhode Island. Children living in substandard housing are more at risk for injuries, lead poisoning, asthma, and malnutrition. /2004/ Research shows that there are strong links between substandard housing and educational disadvantages. Eighty percent of the state's housing stock predates 1978, when lead paint was banned //2004//. It is estimated that 9,900 of Rhode Island's rental units have physical defects. Eighty percent of these units are located in Rhode Island's urban communities.

Rhode Island is one of the least affordable housing markets in the nation (only Virginia and New York are worse). ***/2006/ In 2003, the average rent for a two-bedroom apartment in Rhode Island was $1,032. To be able to afford this rent, a worker would have to earn $19.85 per hour for 40 hours per week. This is nearly three times the state's new minimum wage of $6.75 per hour //2006//***. There are 17,000 Rhode Islanders on waiting lists for subsidized or public housing and the waits range from 9 months to 9 years depending on the area of the state.

/2005/ The shortage of affordable apartments, the dwindling availability of subsidized housing, and high home heating costs have caused many Rhode Islanders to double-up, resulting in overcrowded and unstable living conditions. Almost half of all families (43%) with children in the Rhode Island shelter system had been doubled-up with family members or friends just before moving to a shelter //2005//. Homeless children are more likely to get sick, have poor nutrition, develop mental health problems, have academic problems, and experience violence than children who are not homeless are.

/2006/ The number of families seeking shelter increased 9% in 2004 from the previous year. People who found themselves to be homeless for the first time in 2004 were more likely to be employed (18.6%), were slightly more educated (28% had some college education), and were less likely to have drug and alcohol problems than the chronic homeless. Reflecting an all time high for the third year in a row, 6,020 people entered an emergency shelter during 2004. The number of families in shelters increased 8% to an all time high of 794 and the number of children increased by 8% to 1,564, the second highest number ever for the shelters. Blacks were six times more likely to be in an emergency shelter compared to Whites. The number who had no permanent place to live for more than a year doubled from 8% to 16% //2006//.

The widespread recognition that child care is a fundamental need has resulted in statewide efforts to assure a safe and nurturing learning environment in other settings as well (i.e. infant and pre-school

child care, Head Start, school-age child care, and full-day kindergarten). /2004/ In Rhode Island in 2000, 62% of children under age six (45,820) had all parents in the work force, which is higher than the national average of 59% //2004//. /2005/ Between 1990 and 2000 in Rhode Island, the number of children living in low-income working families (full time work and income below 200% of the poverty level) increased 18% from 28,000 children to 33,000 children. This is 15% of all children, lower than the national average of 19% //2005//. Rhode Island, under a 1998 childcare law (Starting Right), is the only state that has a legal entitlement to a childcare subsidy for income-eligible families. Working families with incomes up to 225% of the federal poverty level are entitled to a childcare subsidy for their children up to age sixteen. Co-payments are required for families with incomes over the federal poverty level.

Success in school is the objective and the measure of much family health work, and the highest priority of families as well. In Rhode Island, there has been intense debate about public education and schools, with new laws, new funding, and new measures for evaluation and accountability. School facilities are deteriorating and sometimes environmentally unhealthy. Schools are also responding to new challenges with school-based health, mental health, nutrition, and other services.

With respect to public education for children through grade 12, Rhode Island recently put in place an accountability system that measures the performance of students on statewide tests in every school in the areas of math, reading, writing, and health. Schools in which 50% or more of the students achieve the state standards in reading, writing, and math are classified as high-performing; schools in which 33% or more of the students score significantly below standards or do not take the test are classified as low-performing; and schools that fall in between the two categories are considered to be moderately performing.

/2006/ Rhode Island's accountability system shows that, in 2004, 53% of schools in Rhode Island were categorized as high performing, 21% as moderately performing, and 26% as in need of improvement. In the state's core communities, only 12% of schools were high performing and 65% were in need of improvement. Of the 83 schools in need of improvement in 2004, 28 were considered to be making progress and 55 were not considered to be making progress. Seventy-six percent of the schools not making progress were located in the state's core urban communities //2006//.

Spanish is the most commonly spoken language of Rhode Island's public school students who are English language learners, which is consistent with the increase in the Hispanic child population in Rhode Island. Nearly 4 out of 5 English language learners in the state attend school in the cities of Central Falls, Pawtucket, and Providence. ***/2006/ Central Falls serves the largest percentage of English language learners student population in Rhode Island at 28% of the total number of students. Providence (18%) and Pawtucket (9%) follow //2006//***.

/2005/ Research shows that frequent moves can have a negative effect on school performance and behavior and may affect other areas of child well-being Between 1997 and 2001, 47% of children ages birth to five living in the state's core cites experienced one or more moves, compared to 26% of children ages birth to five living in the remainder of the state. Central Falls (25%), Providence (22%), and Woonsocket (21%) had the highest percentages of children under six years of age who moved more than once //2005//.

Students in Rhode Island become adults in Rhode Island. /2004/ In 2000, 81.9% of Rhode Island adults had a high school diploma //2004//. The proportion of residents aged 25 and up with at least a high school diploma is the smallest among the six New England states, and the proportion with at least a four-year college degree is second to the smallest - ahead is only Maine. /2004/ The high school graduation rate for Hispanics, at 63%, was the lowest of any racial or ethnic group in RI in 1999-2000. Between 1997 and 2001, 15% of all births in Rhode Island (and 26% of all births in the state's core urban communities) were to mothers with less than a high school education //2004//.

/2005/Rhode Island has education levels nearly equal to U.S. averages but lags behind other New

England states on almost all levels of educational attainment. Compared to the other New England states, Rhode Island has the highest percentage of residents without a high school diploma. Of these adults, 37% have less than a 9th grade education. In Rhode Island between 1998 and 2002, 12% of infants were born to fathers without a high school diploma and 15% were born to mothers without a high school diploma //2005//.

A report issued recently by the Nellie Mae Foundation and Jobs For the Future, titled "Rising to the Challenge", estimated that 47% of Rhode Islanders can not read or do math well enough to perform the duties expected of them in today's workforce. In Rhode Island, an estimated 368,000 adults need literacy instruction. However, only 5,592 adults were served last year. Of the 5,592 served, 35% were enrolled in basic courses, 27% in secondary level courses such as GED preparation, and 38% in English as-a-second-language courses.

The Family Independence Program (FIP) is the state's welfare reform program, as set forth in the Rhode Island Family Independence Act of 1996. The FIP seeks to help low-income families by providing the supports (including subsidized health insurance, childcare, and work-readiness activities) that families need in order to obtain and keep a job. ***/2006/ As of December 2004, there were 10,231 adults and 23,917 children in Rhode Island enrolled in FIP. Nearly three-quarters of all FIP beneficiaries are under the age of 18. Three out of four children enrolled in FIP are age 12 and under, and almost half are under age six. Seventy-nine percent of children enrolled in FIP live in the state's core cities.***

Beginning in September of 2004, families who have been sanctioned for a total of 24 months for failing to enter into an employment plan or comply with the employment plan without good cause have their entire cash benefit terminated (full family sanction). Full family sanction replaced a system of graduated penalties applied only to the parent's portion of the benefits. Under full family sanction, a graduated system will still apply prior to the 24th month. As of December 31, 2004, 159 cases had been closed as a result of the full family sanction. To have cash benefits reinstated, the adult must reapply for benefits, sign an employment plan, and be in compliance with that plan for two weeks //2006//.

In addition to the state's health care program RIte Care (including RIte Start), the childcare program Starting Right, and the FIP welfare reform program, another important emerging statewide initiative is the Rhode Island Department of Human Services' (RIDHS's) Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation (CEDARR) initiative for children with special health care needs (CSHCN). ***/2006/ Through this initiative, RIDHS is defining a statewide set of services to assure timely access to appropriate, high quality, coordinated services for CSHCN and their families through certified "centers of excellence" called CEDARR Family Centers. The services available through CEDARR Family Centers are expected to significantly enhance the range and quality of services available to CSHCN and their families in Rhode Island.***

There are currently three CEDARR Family Centers in place and operating in Rhode Island. The centers provide family-directed coordinated services to help families navigate the services available for CSHCNs, including CSHCNs with developmental, behavioral, or emotional problems. The second phase of the CEDARR initiative was the development of certified direct services to fill in the gaps in the existing service delivery system. Identified gaps include therapeutic services in child and youth care, home-based therapeutic services, and personal assistance services and supports (PASS) services. These direct services are offered through the CEDARR Family Centers //2006//.

/2004/ Despite recent expansions in the state's Medicaid managed care program, 6.2% of Rhode Island's population was uninsured for health care in 2000. This was the lowest rate in the nation. The proportion of working-age Rhode Islanders who are uninsured continues to drop in Rhode Island. In 1996, the percentage was 10.9% and in 1998 it was 10.2%. Younger Rhode Island adults ages 18-34 are more likely to be uninsured than older adults (14.1% verses 7.6% for those ages 35-49 and 5% for those ages 50-64). Seven percent (7%) of adults living with children were uninsured in 2000, while

11.6% of adults living without children were uninsured during this same year. The rate of uninsured adults living with children declined from 10.8% in 1996 to 7% in 2000.

After a three-year increase, uninsurance rates for working-age Rhode Islanders who earn less than $25,000 a year declined by 20%, from 25.6% in 1998 to 21.1% in 2000. The likelihood of being insured is highly associated with employment status. The rate of uninsurance (7% in 2000) continues to be lowest for those who work for wages. Self-employed Rhode Islanders are three times more likely than Rhode Islanders who work for wages to be uninsured (21.8%). Unemployed Rhode Islanders continue to have the highest rate of uninsurance (30.6%).

Males are more likely to lack health insurance than females. The gap is widening and in 2000, males, at 12.8%, were twice as likely as females (6.2%) to be uninsured. The percentage of uninsured Whites has remained constant at about 9% for the past four years. The uninsured rate varies by race and ethnicity. The rate for Blacks is almost three times higher than the White rate at 22.2%. The Hispanic uninsurance rate has shown the fastest decline from 27.6% in 1996 to 5.8% in 2000.

/2006/ Rhode Island's emergency room current utilization rates exceed the United States and Northeast averages by 4% and 9%, respectively. Based on these rates and the projected population, emergency room visits in Rhode Island will total 460,000, nearly 30,000 more emergency room visits as compared to 2000. As expected, young working age individuals (18-44 years), including the uninsured, comprise the largest population (44%) of these visits. In the absence of a state-supported hospital, all of the hospitals in the state are legally mandated to treat the uninsured //2006//.

As of 2001, 4.5% of children under age 19 in Rhode Island were uninsured, the lowest rate in the nation. Nationally, 13% of children were uninsured. The rate of uninsured children in Rhode Island has been reduced by more than half over the past six years. As of 2001, there were 11,000 uninsured children in Rhode Island. Of these an estimated 7,000 were eligible for RIte Care but un-enrolled. Ninety-one percent (91%) of Rhode Island's uninsured children live in working families. Eighteen percent of uninsured children live in families with incomes less than 100% of poverty, 36% with incomes 100% - 174% of poverty, 9% with incomes 175% - 249% of poverty, and 36% with incomes greater than 250% of poverty //2004//.

The state's Medicaid managed care program; RIte Care has had a profound impact on the state's health care system. The comprehensiveness of services offered under RIte Care has made it a national model. Rhode Island increased eligibility for RIte Care, through the federal Children's Health Insurance Program (CHIP), to include coverage children up to age 19 in families with incomes of up to 250% of poverty. Rhode Island has made significant progress in reducing the number of uninsured children in the state by enrolling eligible children in RIte Care.

RIte Care covers undocumented children up to age 19 in income-eligible families and the parents of eligible children in families with income up to 185% of RIte Care was also expanded eligibility to include pregnant women up to 350% and child care providers who serve low-income children. Initially (in 1995), about 75,000 adults and children were covered by RIte Care. By July 2000, RIte Care increased the number of previously uninsured enrollees from to 108,000, up from 101,000 just two months before. /2004/ Enrollment seems to have leveled off and as of December of 2002, 117,507 individuals are enrolled in Rite Care. Nearly two-thirds of these individuals are children under the age of 19 years (76,151). In 1995, the number of children enrolled in RIte Care was 43,413 //2004//.

/2006/ As of December 31, 2004, two-thirds (80,953) of the RIte Care members who qualify based on income were children under age 19. In addition, there were 44,199 low-income parents enrolled in RIte Care as of December 31, 2004. Of these parents, 10,098 (23%) received RIte Care because they were enrolled in FIP. As of 2003, 4.8% of Rhode Island's children under age 18 were uninsured, compared to 11.6% of children nationally. Two-thirds of Rhode Island's uninsured children live in working families //2006//.

In April of 2001, the Rhode Island Department of Human Services (RIDHS) launched the RIte Share initiative as a way to control increasing costs associated with RIte Care and to strengthen the employer-sponsored health insurance infrastructure in the state. RIte Share requires RIte Care applicants with access to employer-sponsored insurance to participate in their employer's insurance plan. RIte Share pays the employee's share of the cost for enrolling in an approved employer-sponsored family or individual health insurance plan.

Eligibility guidelines are the same as for RIte Care (i.e. the employee must have a RIte Care eligible family member in order to enroll in RIte Share). RIte Share provides the full range of RIte Care benefits to families by covering RIte Care services not included in the employer's health insurance plan. As of April of 2002, 866 individuals were enrolled in RIte Share. ***/2006/ During 2004, 2,142 adults and 3,734 children were enrolled in RIte Share //2006//***.

Beginning in January of 2002, families participating in RIte Care or RIte Share with incomes above 150% of poverty began to pay a monthly premium, ranging from $61.00 to $92.00, depending on family income. If two months go by with no payments made, families are dis-enrolled from health insurance and are ineligible for RIte Care or RIte Share for a period of four months. Pregnant women and children under one year of age are not dis-enrolled for failure to pay the premium.

/2004/ In February of 2002, RIDHS issued a follow-up survey and found that of the 4,805 premium bills that RIte Care sent out on December 15, 2001, 63% of the members had paid by January 15, 2002. A later subsequent analysis of 1,853 families who were first sanctioned in 2002 showed that 1,101 (59.4%) of those families returned to RIte Care coverage and an additional 82 (4.4%) met other criteria under Medical Assistance regulations that allowed specific family members to continue coverage. The remaining 670 families (36.1%) of those receiving a first sanction did not return to coverage.

/2006/ More recently, RIDHS received a waiver to enroll children with special health care needs from Medicaid fee-for-service to RIte Care on a voluntary basis, through Neighborhood Health Plan of Rhode Island. Originally, about 7,800 children with special health care needs were on Medicaid fee-for-service//2006//. More than half of these children (59%) qualify for Medicaid due to Supplemental Security Income (SSI) eligibility, 13% qualify under the Katie Beckett provision, and the remainder (28%) are Medicaid-eligible by virtue of their qualification under Rhode Island's adoption subsidy program.

***/2006/ The majority of Rhode Islanders (403,000) are commercially insured. There are basically three major commercial health insurance plans in Rhode Island, Blue Cross & Blue Shield of Rhode Island (including its HMO subsidiary Blue Chip), United Health Care of New England, and Blue Cross of Massachusetts, which together cover 88% of the state's commercially insured population. In 2003, monthly premiums in Rhode Island were 25% higher than in the nation ($248 verses $198), but 5%
less than in New England ($248 verses $261) //2006//***.

Statewide Health Care Delivery Systems

Rhode Island has a long tradition of public investment in health services, with special attention to pregnant women, infants, and children with special health care needs (CSHCN). A well-distributed mix of private practitioners, multi-specialty groups, and a statewide network of community health centers and hospital-based primary care clinics provide health care. Tertiary perinatal and pediatric centers in Providence back up the state's 8 acute care hospitals.

Although Rhode Island has a large health care workforce relative to its population, primary care access remains a problem among the state's most vulnerable residents. The communities of Providence, Woonsocket, Pawtucket, Central Falls, Newport, East Providence, South Kingstown, Burrillville, and Hopkinton have been designated Health Professional Shortage Areas (HPSAs) by the federal Bureau of Primary Health Care (BPHC) and there are often care delays and other symptoms

of stressed and understaffed providers in these neighborhoods. The state correctional and mental health hospital facilities and the Narragansett Indian Health Center have also been designated as HPSAs by the BPHC.

/2006/ Forty-three percent of the children who were enrolled in Rite Care, RIte Share, or Medicaid fee-for-service received any dental service during 2004. In Rhode Island, an average of 541 children under age 21 were treated each year for a dental-related condition in hospitals during the period 2001-2003. Between 1998 and 2004 in Rhode Island, an average of 46 children under age 18 years of age were hospitalized each year with a diagnosis that included an oral health condition //2006//.

State law requires schools to provide dental screenings for all newly enrolled students, annually for children in grades K through 5, and at least once between grades 7-10. There is a decreasing supply of dentists nationally and locally, most acutely in traditionally under-served areas. /2004/ As of 12/30/02, there were 474 active licensed dentists in Rhode Island, representing a dentist to population ratio of 1:2,136 (the optimal ratio would be between 1:1,500 and 1:1,700.

Publicly funded mental health services for children in Rhode Island are provided by the state Department of Children, Youth, and Families (DCYF) through contracts with community-based organizations or through RIte Care and mental health care for adults is provided by the state Department of Mental Health, Retardation, & Hospitals (MHRH) directly or through RIte Care. In 2002, 9% of children who were enrolled in Medicaid received a Medicaid funded mental health service. Low-income, uninsured individuals are dependent upon the state's community mental health system for services.

/2006/ In Rhode Island, private insurance rates for behavioral health services were reduced in the 1990s, and although rates for some services have been increased, many behavioral health services have yet to be adequately reimbursed. Public services have generally not been adequately funded to meet the needs presenting to the system. In Rhode Island, fewer psychiatrists work in private practice than among physicians as a whole. Among all physicians excluding psychiatrists, 68% work in private practice; among psychiatrists, this number is just 40%.

It is generally more difficult to schedule timely appointments with psychiatrists for new patients in Rhode Island and primary care physicians and general internists both report that psychiatrists are the specialists to whom they have the most difficulty making referrals. Child psychiatrists, in particular, report long wait times for new patients to make non-emergency appointments. Qualitative data suggests that patients who belong to cultural and linguistic minority groups face particular challenges accessing appropriate care in Rhode Island.

Nearly 50% of individuals receiving care for behavioral health problems receive their care from primary care physicians, predominantly in the form of medications, but there is rarely an established process for PCPs to communicate with psychiatrists or a reliable means of reimbursement for such activities. As a result, PCPs often find it difficult to consult with psychiatrists about patient management //2006//.

State Title V Priorities

/2004/ The Rhode Island Department of Health's Division of Family Health (DFH) has primary responsibility for assessing the health and developmental needs of young families and children in the state, for planning effective measures to address those needs, for evaluating programs and policies affecting the health and development of children, and for the management of maternal and child health programs providing services to women and children through community-based agencies. ***/2006/ During each Title V MCH needs assessment year, the DFH identifies its new priorities from a longer list through a comprehensive strategic planning process. The DFH's strategic planning process is one that relies on data collection and surveillance, parent and***

community input, and interagency collaboration. Community input is gathered from community meetings, a public hearing, and parent surveys. At the same time, the DFH analyzes vital statistics, newborn screening, KIDSNET, parent surveys, and many other sources of information for critical family health issues that need attention. For FY2006, the DFH has come up with the following 9 strategic priorities for action under Title V:

· Improve maternal health through the reproductive lifespan;
· Promote healthy lifestyles and healthy weights for all;
· Engage, empower, support, and inform parents;
· Support safe and healthy communities for children and families;
· Address the social, emotional and behavioral health needs of the MCH population;
· Improve pregnancy outcomes;
· Ensure a medical home for all Rhode Island families;
· Enhance maternal and child health programs; and
· Promote healthy human development in children, adolescents, and families.

All of these priorities relate to the state's plans for Healthy People 2010 objectives. The annual Title V process also sets priorities for its other programs (including Immunization, Lead Poisoning, Family Planning, WIC, School and Adolescent Health) and so "Family Health in Rhode Island (FHRI) 2006" is intended to be a comprehensive and integrated plan //2006//.

B. AGENCY CAPACITY

/2006/ The federal Maternal & Child Health (MCH) Program has a rich history in the United States. Its foundation can be traced to the late 1800s as growing concerns emerged regarding how our nation should protect children for a host of threats, including abuse, childhood labor, disease, and the ill effects of unclean water and milk, poor sanitation, and an unsafe environment. The first decades of the 1900s were times of increasing concern about assuring that children and their families had access to adequate and appropriate health care and to health and social systems that understood the special development needs of children, including children with special health care needs (CSHCN). President Franklin Roosevelt signed the Social Security Act into law in 1935, during the Great Depression. Title V of this legislation provided programs for maternal, infant, and childcare, as well as a full range of medical services for children, including CSHCN.

While MCH in the United States has since undergone a fitful evolution over the past 100 plus years, public health concerns related to children and their families have always been foremost to MCH. The MCH Program remains committed to ensuring that society fulfills its responsibility to all children (including CSHCN) and women of childbearing age by assuring comprehensive, coordinated, accessible, and family-centered health care services that are culturally and ethnically sensitive at the federal, state, and local levels. MCH's application of public health's preventive philosophy illuminates why MCH has its origins in child development from conception to adulthood and has a continuing focus on assuring that the myriad systems designed to support the optimal growth and development of all children and their families are coordinated, cost-efficient, and effective.

Chapter 23-13 of the Rhode Island General Laws (1937 & 1999) designates the Rhode Island Department of Health (HEALTH) as the state agency responsible for administering the provisions of Title V of the federal Social Security Act in Rhode Island relative to maternal and child health services. As the recipient of the state's federal Title V MCH block grant funds, HEALTH's Division of Family Health (DFH) plays an important role in addressing the MCH needs of children (including CSHCN) and their families in Rhode Island. Like the federal MCH Program, the DFH believes that preventive measures directed at children and their families

have the greatest potential for positive health achievements; therefore, assuring optimal growth and development, detecting health problems early, and instilling an appreciation for positive health seeking behaviors all have payoffs, not only during childhood, but during adulthood as well.

The DFH utilizes its federal MCH funds to assess, evaluate, promote, and improve health care and social systems in order to assure the essential receipt of services by children and their families in Rhode Island's communities and to further foster culturally appropriate systems of care that encourage family involvement in decision-making. Although most of the services needed by Rhode Island's children and families are well beyond the capacity of the DFH to provide, the DFH is committed to identifying what services are needed and ensuring that children and families access identified needed services through the development of new and/or enhanced systems of care in partnership with federal, state, and local government agencies; private organizations; and families. Under the overarching umbrella that makes up its Title V priorities, the DFH is committed to ensuring that all Rhode Islanders (especially those who are the most vulnerable) have access to a full array of comprehensive, quality, health care services designed to help them reach their full physical, mental and emotional potential //2006//. /2004/ For a summary of the DFH's capacity to provide:

1) preventive and primary care services for pregnant women, mothers, and infants,

2) preventive and primary care services for children, and

3) services for CSHCN

please refer to the attachment.

With respect to providing rehabilitative services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI to the extent medical services for such services are not provided under Title XIX, it is important to point out that Rhode Island is a 1914 A state (i.e. all children with SSI receive Medicaid benefits which includes rehabilitative services) //2004//. ***/2006/ The DFH worked closely with the RI Department of Human Services (RIDHS) Disability Determination Unit to develop a "welcome Packet" for families with CSHCN who have applied for SSI benefits. The packet includes linguistically and culturally appropriate materials on a variety of topics, including CEDARR, Family Voices, and the RI Parent Information Network (RIPIN). Through this project, the DFH ensures that families with CSHCN who receive SSI and those that are turned down have timely access to information about CSHCN services and supports in Rhode Island //2006//***.

/2004/ With respect to providing and promoting family-centered, community-based, coordinated care (including care coordination) for CSHCN, and facilitating the development of community-based systems of services for CSHCN and their families, it is important to point out that much of the DFH's work in these areas focuses on infrastructure building activities. In fact, the DFH provides few direct services to the state's maternal & child health populations, including CSHCN. The DFH is also committed to ensuring that services are culturally competent. Rhode Island has one of the highest percentages of foreign-born residents in the nation and much of its recent population growth can be attributed to its minority residents. DFH staff has received training on cultural competency and the DFH employs culturally diverse parent consultants. The DFH also employs culturally diverse staff and supports many community-based initiatives in communities in Rhode Island. DFH information and educational materials are written at a sixth grade reading level and most materials are available in English and Spanish with a limited selection available in other languages based on program needs. In addition, the DFH's Communication Unit continues to work to increase the DFH's reach in Rhode Island's Latino community.

As previously noted, Chapter 23-13 of the Rhode Island General Laws (1937 & 1999) designates the Rhode Island Department of Health (HEALTH) as the state agency responsible for administering the

provisions of Title V of the federal Social Security Act in Rhode Island relative to maternal and child health services.

Other state statutes directly involving the DFH include the following:

Chapter 16-21-7 of the RIGLs (1938 & 1996) requires local schools to have a school health program that is approved by HEALTH and the Rhode Island Department of Education (RIDE).

/2006/ Chapter 23-5-20.5 of the RIGLs (2002) establishes standards for the maintenance of pre-1978 rental property in Rhode Island and provides property owners with access to liability coverage for lead poisoning //2006//.

Chapter 23-1-18 of the RIGLs (1966 & 1993) authorizes HEALTH to require the reporting of immunization status for the purpose of establishing and maintaining a childhood immunization registry for children under the age of 18 years old.

Chapter 23-1-49 of the RIGLs (1985 & 1997) authorizes HEALTH to establish and maintain registries for traumatic brain and spinal cord injuries //2004//.

/2005/ Chapter 213-13-3 of the RIGLs (2003) creates a birth defects surveillance registry //2005//.

/2004/ Chapter 23-13-13 of the RIGLs (1979) requires all newborns to be screened for hearing impairments.

Chapter 23-13-14 of the RIGLs (1987 & 2001) requires all newborns to be screened for metabolic, endocrine, and hemoglobinopathy disorders.

Chapter 23-13-16.1 of the RIGLs (1988) requires hospitals to submit statistics relating to the annual rate of caesarian sections, primary and repeat, to HEALTH.

Chapter 23-13-17 of the RIGLs (1987 & 1996) designates HEALTH as the state agency for administering the provisions of the WIC Program.

Chapter 23-13-20 of the RIGLs (1988) authorizes HEALTH to establish a family life and sex education program to assist in the establishment of community networks in the maternal and child health planning areas with high rates of teenage pregnancy.

Chapter 23-13-21 of the RIGLs (1988) authorizes HEALTH to establish a payer-of-last-resort program to cover the costs of outpatient family planning counseling and comprehensive reproductive health services for men and women who are uninsured and ineligible for Medicaid in RI.

/2006/ Chapter 23-13-22 of the RIGLs (2004) authorizes the transfer of the Early Intervention Program from HEALTH to the Rhode Island Department of Human Services (RIDHS) //2006//.

Chapter 23-24.6 of the RIGLs (1991) authorizes HEALTH to establish a comprehensive statewide program to reduce the prevalence of childhood lead poisoning in the state.

Chapter 40-19.1 of the RIGLs (1997) requires HEALTH, the RI Department of Human Services (RIDHS), the RI Department of Children, Youth, & Families (RIDCYF), and the RI Department of Education (RIDE) to develop a comprehensive statewide plan to prevent and reduce the incidence of unwanted pregnancies among adolescents in RI.

These and other state statutes that indirectly impact DFH activities are included as an attachment.

CSHCN Program Capacity

The DFH's OFRCSHCN ensures a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care, which are essential for effectively fostering and facilitating activities. The OCSHCN collaborates with other state agencies and numerous private organizations and associations. These collaborations include the following:

State Collaboration With Other State Agencies & Private Organizations //2004//

/2006/ Rhode Island Department of Human Services (RIDHS): The DFH has a formal Medicaid agreement with RIDHS for Early Periodic Screening, Diagnosis, & Treatment (EPSDT) services. It also has a memorandum of agreement with RIDHS to provide RIDHS to share data related to childhood lead poisoning //2006//. /2004/ In addition to formal agreements, staff from the DFH provides consultation and professional expertise to the RIDHS in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions. The DFH also collaborates extensively with RIDHS to create a statewide infrastructure for addressing the problem of childhood lead poisoning among children with Medicaid in Rhode Island. RIDHS supports four regional certified lead safe centers, which provide lead poisoned children with Medicaid with comprehensive case management services and coordinated linkage to other services and supports. It is notable to point out that RIDHS covers replacement windows as a medically necessary service for lead poisoned children through Medicaid.

Child Development Center (CDC): The OFRCSHCN has a cooperative agreement with and supports the CDC, which is a RIDHS certified CEDARR Family Center located at Rhode Island Hospital. The CDC provides specialty and sub-specialty services to medically complex CSHCN from birth to 21 years of age. The DFH's OCSHCN is working closely with the CDC on issues relating to quality of care, identification of services, and access to reimbursement //2004//. /2005/ Two OCSHCN parent consultants have been assigned to work at the CDC on these issues //2005//.

/2004/ Rhode Island Hearing Screening Assessment Program (RIHAP): RIHAP provides support and follow-up for children with hearing impairments identified through the DFH's newborn screening process. DFH participate on RIHAP's Hearing Screening & follow-Up Committee on an on-going basis.

Rhode Island Transition Council: The DFH continues to participate on the RI Transition Council, which was established by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life.

Child Maltreatment Surveillance Project: The goals of this initiative include evaluation alternative approaches to surveillance of fatal and non-fatal child maltreatment and piloting methods that may be used for surveillance of violence. DFH staff meets with representatives from the Child Advocate's Office, the Medical Examiners' Office, the Attorney General's Office, the RIDCYF, Brown University, and Hasbro Children's Hospital staff regularly. The group reviews hospital discharge data (including emergency room data) of all fatal cases of children under 21 years of age who had one or more of 30 ICDP codes related to possible child maltreatment to look for "missed opportunities". The group also compares hospital discharge data of non-fatal cases of children under 21 with RIDCYF case data. The grant provides the DFH with a promising opportunity to evaluate and pilot new, more sophisticated approaches to surveillance in this area.

Family Voices Rhode Island: The OCSHC works closely with leadership from the Rhode Island Chapter of Family Voices on an ongoing basis. The Director of Family Voices meets regularly with the DFH's Medical Director and the Chief of the OCSHCN. The Director of Family Voices is a member of the OCSHCN's SSI Team. Family Voices RI is one of a few state Family Voices chapters to implement a Family-to-Family Information Center. In addition, the Director of Family Voices participated in the planning phase of the DFH's recent reorganization of the OCSHCN.

Rhode Island Parent Information Network (RIPIN): RIPIN is a statewide, non-profit agency that provides information, training, support, and advocacy to parents seeking help for their children in

Rhode Island. The DFH works closely with RIPIN on several initiatives. RIPIN provides training and oversees the administrative aspects of the DFH's Parent Consultant Program (including the EI Parent Consultant Program). In addition, the DFH's toll-free Family Health Information Line refers parents who express interest in child development, school readiness, literacy, discipline, violence prevention, disabilities, special education, transitions, and health-related issues to RIPIN and other appropriate community-based resources.

Rhode Island Chapter of the March of Dimes (MOD): The DFH is collaborating with the MOD on two major initiatives. The first one focuses on ensuring that women (especially low-income women) in Rhode Island have access to folic acid education with folic acid prior to becoming pregnant or early in pregnancy in order to prevent birth defects. The other initiative focuses on working with the MOD and other key community partners to develop statewide initiatives to reduce prematurity in Rhode Island //2004/.

/2006/ Interagency Coordinating Council on Environmental Lead (ICCEL): The ICCEL was created as a part of the new Lead Hazard Mitigation Law passed in June of 2002, and is chaired by the Director of HEALTH, with members that include the RIDHS, the RI Department of Environmental Management (RIDEM), the Office of the Attorney General, the RI League of Cities and Towns, and the RI Housing Resources Commission. The ICCEL is charged with the responsibility to oversee the implementation of the Lead Hazard Mitigation Law.

Rhode Island School for the Deaf: The DFH has a cooperative agreement with the Rhode Island School for the Deaf for the purposes of systemically assessing, developing, and implementing strategies for tracking children beyond age five by including school hearing screening information and results in KIDSNET //2006//

/2004/ Brain Injury Association of RI: The DFH's Traumatic Brain & Spinal Cord Injury (TBSCI) Program is mandated to maintain a registry of individuals with traumatic brain and spinal cord injuries in RI for the purpose of helping children and adults with TBSCIs access appropriate services, including SSI and rehabilitative services. The TBSCI Program sends individuals with TBSCIs a follow-up letter informing them of the Brain Injury Association of RI as a potential resource.

State Support for Communities

Ready to Learn Providence (RLP): The DFH continues to support the Providence Plan's community-driven strategic planning initiative to increase utilization of MCH services (including CSHCN services) among young families living in the City of Providence. RLP, through federal Early Learning opportunity funding, will continue to implement activities relating to improving the quality of child care through expanding and better connecting providers to professional development, expanding the capacity and cultural competency of existing early childhood learning programs, and institutionalizing a kindergarten transition initiative designed to better prepare children to learning at school entry. Linking children, including CSHCN, to needed health related services through a "medical home" represents an important part of RLP activities. In addition, parents participate in all phases of RLP activities //2004//.

/2005/ Newport County, Washington County CATCH, & Mt. Hope CATCH: The DFH continues to support these community driven strategic planning initiatives to implement strategies to better connect children, including CSHCN, in Newport County, Washington County, and the Mt. Hope section of Providence with a "medical home" //2005//. /2004/ Strategies include providing "medical home" training to pediatric and social service providers and families, developing ways to utilize existing data on families without "medical homes" (i.e. local emergency room records), connecting pediatric and social service providers to existing case management resources, and securing funding to support case management for families who do not meet existing criteria for such services. Newport CATCH received $50,000 per year for two years to implement its strategic plan. Newport County's experiences in developing an infrastructure to support a coherent and integrated system of care for children, including CSHCN, will be shared with other communities throughout the state for possible

replication purposes. As with RLP, parents participate in all phases of CATCH activities.

Successful Start: ***/2006/ The DFH's early childhood comprehensive systems development initiative, Successful Start, engaged in a two-year, statewide planning effort to assess capacity, quality, and integration issues surrounding five core components of the state's existing early childhood system //2006//***. The five core components include "medical homes", social and emotional development, child care, parenting education, and family support for all children, including CSHCN. ***/2006/ Beginning in the summer of 2005, the plan developed for Successful Start will go into implementation. Parent involvement will be a key to success in the implementation phase. As with the RLP and Newport County CATCH initiatives, parents will participate in all phases of Successful Start activities //2006//***.

/2004/ Coordination With Health Components Of Community-Based Systems

Healthy Schools!/Healthy Kids! (HS/HK): The DFH's Office for Family, Youth & School Success (OFYSS) is responsible for coordinating the internal work of HEALTH relating to the health of school-age children. There are many opportunities to address the critical health issues of school-age children, including obesity, oral health, chronic conditions, tobacco use, mental and behavioral health concerns, school environmental concerns, and access to health care. The OFYSS convened an internal working group to develop an ideological framework for organizing work, to make recommendations for coordinating work, and to identify information needs. Recommendations included the initiation of formative research with schools and communities to identify key issues and concerns that the OFYSS can address and the preparation of a report identifying state and local policies and programs that enhance or impede the health of school-age children in RI.

The DFH's Family Outreach Program (FOP) provides home assessments, connection to community services, and help with child development and parenting for almost one-third of families with newborns each year. Home visitors also serve as the follow-up staff for the DFH's Newborn Screening, Early Intervention, Lead Poisoning, and Immunization Programs. Recent data suggest an improvement in the acceptance rate for "hard-to reach" families. The DFH is working to build prenatal home visiting capacity and develop greater linkages with CEDARR.

Coordination of Health Services with Other Services at the Community Level

The DFH's Newborn Screening Program provides universal newborn screening and follow-up for a growing list of metabolic, endocrine, and blood disorders. The program also provides hearing screening and developmental risk assessments for newborns. A newborn developmental risk module, integrated with a new electronic birth certificate system, began rolling out in May of 2003. Consumer input into genetics and newborn screening policy development was obtained through outreach, focus groups, surveys, and other means. The DFH worked closely with local hospitals to implement the new integrated electronic developmental risk assessment/birth certificate system in RI.

As part of the DFH's genetics initiatives, DFH parent consultants worked with parents to develop "medical passports" for families with CSHCN, which contain information about services for CSHCN and their families in Rhode Island. The DFH will also continue to work with the New England Regional Genetics Group (NERGG) for technical assistance in implementing HEALTH's statewide genetics plan. The genetics plan includes a focus on issues related to access to genetics services, including genetics counseling.

The DFH's Birth Defects Surveillance Program is working to ensure that children with birth defects have a "medical home" and that families have access to preventive services. The DFH designed a template for for birth defects, a data book, and newsletter. The DFH's Birth Defects Advisory Committee will continue to include parents to ensure their participation in monitoring the program and to ensure that all children with birth defects have a "medical home". In addition, a DFH parent consultant is working with the Advisory Committee to develop and implement statewide birth defects prevention strategies.

The DFH's Connecting Families with Technology (CFT) Project linked families with CSHCN and family child care providers with information and support through the Internet. The DFH supported computer hardware, Internet access, and training activities. Families with CSHCN and family child care providers may be isolated and often have limited access to information and support. The DFH has successfully integrated CFT activities into the work of the Day Care Justice Coop and Family Voices. The DFH successfully worked with the RI Parent Information Network (RIPIN) to seek sources of long-term support for CFT activities //2004//.

C. ORGANIZATIONAL STRUCTURE

/2004/ The DFH is a major component of HEALTH, which is a cabinet agency that directly reports to the Governor. The DFH is organized into five sections: the Office for Children's Preventive Health Services (CPHS), the Office for Families Raising Children with Special Health Care Needs (OFRCSHCN), the Office for Family, Youth, & School Success (formerly known as the Adolescent & Young Adult Health Unit), the Office for Women, Infants, & Children (WIC), and the Office of the Medical Director. The DFH has a Medical Director, an Assistant Medical Director, parent leadership, appropriate chiefs and program managers, and senior staff responsible for management, data and evaluation, policy, and communications.

The DFH's activities include a special emphasis on eliminating health disparities. In fact, most of the DFH's programs serve a high proportion of low-income, racially and ethnically diverse families. Over the last decade, the DFH has developed a strong Parent Consultant Program, which assures that a wide variety of parents, including those with CSHCN, are included in all aspects of the DFH's programs (i.e. program policy, planning, implementation, and evaluation) on an on-going basis.

Although several of the DFH's programs continue to provide direct services to vulnerable populations (i.e. WIC, Family Resource Counselor Program, Family Outreach Program, Women's Health Screening & Referral Program, Family Planning, Childhood Lead Poisoning Prevention Program, School-Based Health Center Program, Immunization Program, etc.) through contracts with community partners, they have also matured over time and the DFH now focuses much of its resources and efforts on strengthening existing community-based infrastructures, building sustainable systems of care, and assuring effective ongoing quality improvement activities. A good example of this maturation can be found in the DFH's Family Resource Counselor (FRC) Program.

The FRC Program supports FRCs in several community health center and outpatient hospital clinics to link families to important MCH services, including WIC, RIte Care/RIte Share, Food Stamps, and the Family Independence Program (FIP) //2004//. ***/2006/ Four years ago, much of the FRC's focus involved helping the Rhode Island Department of Human Services (RIDHS) identify and enroll newly eligible families into the expanding RIte Care Program //2006//***. /2004/ Recognizing the value of the FRC Program in assuring that families were linked with important services, the RIDHS agreed to provide the DFH with a 90/10 match for the FRC Program, which has served to strengthen the program 1) by leveraging existing Title V dollars and 2) by making FRCs a permanent part of the state's MCH outreach infrastructure //2004//.

/2005/ The DFH has strengthened the FRC Program further be developing a strong support network, which includes Covering Kids RI, the RIDHS, the RI Health Center Association (RIHCA), the state's major health insurance plans, and the Poverty Institute. The network provides training, technical assistance, and policy leadership to the program //2005//.

/2004/ Although the DFH does not have direct responsibility for addressing several important initiatives (i.e. RIte Care/RIte Share, CEDARR, children's mental health, etc.), it has been a visible and effective presence in statewide efforts designed to address concerns related to these initiatives.

For example, the DFH has been participating in Children's Cabinet, the Northeast Injury Prevention Network, Governor's Council on Mental Health, and RIDHS Mental & Behavioral Health Workgroup discussions on the topic of children's mental health needs //2004//. ***/2006/ For example, the DFH's Healthy Child Care Rhode Island Initiative (HCCRI) provides direct training to child care providers on children's mental health, allows childcare providers access to mental health consultation, and offers workshops on various mental health topics for child care providers //2006//***. /2004/ As a way to address emerging consumer concerns relative to the new RIte Care/RIte Share premiums, a DFH staff person continues to participate on the RIte Care/RIte Share Consumer Advisory Committee, which is charged with making identifying issues and making recommendations to the Rhode Island Department of Human Services (RIDHS) //2004//.

/2005/ With respect to recent organizational changes, the DFH revitalized its Office of Children With Special Health Care Needs (OCSHCN) with a new office chief, parent-consultant, and quality assurance specialist in FY2003 //2005//. ***/2006/ The DFH's OCSHCN, now titled the Office for Families Raising CSHCN is currently responsible for overseeing the DFH's former, current, and future CSHCN activities, including the SSI Team, the Disability & Health Program, the Traumatic Brain & Spinal Cord Injury (TBSCI) Program, the Child Maltreatment Initiative, the Child Development Center (CDC), and the Family Outreach Program (FOP).***

In FY2004, the DFH's Early Intervention Program was transferred out of the OFRCSHCN to the Rhode Island Department of Human Services (RIDHS) //2006//. /2004/ The OFRCSHCN will continue to be responsible for addressing the important concerns of families raising CSHCN through advocacy, coordination, and collaboration with other state departments and agencies serving this population and by promoting and monitoring the quality of services that children and families receive.

In addition, the DFH's Adolescent & Young Adult (AYA) Unit was reorganized and expanded in FY2003 and is now titled the Office for Family, Youth, & School Success (OFYSS) //2004//. ***/2006/ In addition to overseeing the DFH's Family Planning Program, Women's Health Screening & Referral Program (WHSRP), Vasectomy Program, School-Based Health Center (SBHC) Program, Men 2B Program, Healthy Child Care Rhode Island (HCCRI), and the state's systems development initiatives (i.e. Ready To Learn Providence, Newport CATCH, South County CATCH, Mt. Hope CATCH, & Successful Start), the OFYSS is responsible for coordinating the internal work of HEALTH relating to the health of school-age children through Health Schools!/Healthy Kids! //2006//***. /2004/ The OFYSS has convened an internal working group to develop an ideological framework for organizing Healthy Schools!/Healthy Kids! work, to make recommendations for coordinating work, and to identify information needs. Recommendations will include the initiation of formative research with schools and communities to identify key issues and concerns that the OFYSS can address and the preparation of a report identifying state and local policies and programs that enhance or impede the health of school-age children in Rhode Island.

More recently, the DFH's Chief of Staff, Janice Cataldo, left for another position in mid-FY2004. Laurie Petrone, formerly the Chief of the DFH's Communications Unit, has assumed the role of Chief of Staff for the DFH. Andrea Bagnall-Degos, formerly the Deputy Chief of the Communications Unit has assumed the chief's role for this unit. The DFH is pleased to report that these transitions occurred simultaneously and smoothly without creating any vacant positions //2005//. ***/2006/ In FY2005, the DFH's key administrator, Jonathan Seamans, left for another position within the Rhode Island Department of Health. He was replaced by Marliot Uzcategui //2006//***.

/2004/ See Attachment for a copy of the DFH's organizational chart //2004//.

D. OTHER MCH CAPACITY

/2006/ There are approximately 64.3 FTEs who work in the Division of Family Health (DFH) as state employees. This number includes staff that provide planning, evaluation, and data

analysis. In addition, the DFH's staffing configuration includes 20 Data Logics employees, 4 independent contractors, 6 temporary employees, 6 summer interns, 2 MPH assistants, and 5 DFH parent consultants. Of the 5 DFH parent consultants, 3 are employed in CSHCN programs. The 5 DFH parent consultants are assigned to the DFH's Family Planning Program (N=1), the WIC Program (N=1), the Immunization Program (N=1), the Childhood Lead Poisoning Prevention Program (N=1), the Birth Defects Program (N=1), and the OFRCSHCN (N=1).

In addition to these 5 parent consultants, the DFH also manages the Pediatric Practice Enhancement Project (PPEP), which has placed nine (15) parent consultants in pediatric practices serving high volumes of CSHCN throughout the state (PPEP parent consultants are supported by the Rhode Island Department of Human Services), supports a portion of the salary of a full-time parent consultant at the Hasbro Children's Hospital Community Asthma Program, or CAP (the Rhode Island Department of Human Service supports the remainder of this individual's salary), and one full-time parent consultant at the Child Development Center, or CDC (an other full-time parent consultant at CDC is supported by the Rhode Island Department of Human Services) //2006//. /2005/ Parent consultants are culturally diverse and are assigned to DFH programs based on the program's need for parent participation and the parent consultant's experience with the program //2005//.

/2006/ All DFH staff, with the exception of the PPEP, CAP, and CDC parent consultants, are centrally located at the Department of Health (HEALTH) //2006//. Below are brief biographies of senior level management staff in lead positions.

William Hollinshead, MD, MPH is the Medical Director for the DFH. He has been active in the leadership of the Association of Maternal & Child Health Programs (AMCHP), the National Academy of State Health Policy, and numerous other organizations. Dr. Hollinshead's recent interests include uses of public health information for leadership and consumer decisions, integrated local family health and development programs for young families, population tracking systems for children, and training of professionals or comprehensive primary care, especially in a managed care environment.

Peter Simon, MD, MPH is the Deputy Director for the DFH. He is responsible for establishing medical policy for all DFH programs. In addition, he provides technical assistance on areas of prevention services for women, infants, children, and adolescents to other divisions within HEALTH (i.e. sexually transmitted diseases, laboratory screening for inborn errors of metabolism and hemoglobinapathies, school health, injury control) and other state agencies //2004//.

/2005/ Laurie Petrone, MS, RD is the Chief of Staff for the DFH. In this capacity, Ms. Petrone is responsible for implementing strategies, management oversight, personnel planning, and providing support to the DFH's medical Director. Her activities include setting program direction and resource allocation with the DFH's Office Chiefs, overseeing the DFH's operations including personnel, purchasing and budgeting, and aligning resources appropriately to meet DFH priorities //2005//.

/2006/ Marliot Uzcategui, BS, is the DFH's Key Administrator. Ms. Uzcategui works in the Office of the Medical Director under the supervision of the Chief of Staff. In this capacity, Ms. Uzcategui is responsible for managing DFH resources (budget and personnel) and investments (purchases and contracts). Ms. Uzcategui monitors and manages federal grants, state and private funding, and other federal and state requirements. She also provides managerial assistance to DFH programs //2006//.

/2004/ Adrianna Leon is the Program Manager for the DFH's Parent Consultant Program. In this capacity, Ms. Leon is responsible for recruiting, supervising, and supporting the DFH's paid parent consultants as partners in outreach, public education, policy development, and quality improvement for DFH programs //2004//.

/2005/ Andrea Bagnall-Degos, MPH is the Chief of the DFH's Communication & Policy Unit, which works in the Office of the Medical Director. In this capacity, Ms. Bagnall-Degos develops and supports

DFH communication & public engagement efforts in partnership with DFH programs, ensures that clear and consistent messages are communicated through all DFH campaigns, provides consultation on communication and policy issues in support of DFH goals, and coordinates policy option development and inter-departmental policy initiatives //2005//.

/2004/ Sam-Viner Brown, SM is the Chief of the DFH's Data & Evaluation Unit, which works in the Office of the Medical Director. In this capacity, Ms. Viner-Brown is responsible for developing, supporting, collecting, and analyzing data for DFH needs assessment, policy development, program management, quality improvement, and reporting purposes in collaboration with national, state, and local partners.

Becky Bessette, MS, RD is the Chief for the DFH's Office for Women, Infants & Children (WIC) Program. In this capacity, Ms. Bessette is responsible for the overall administration of the Immunization Program and the WIC Program, which includes nutrition, farmers market, and breastfeeding initiatives, support and promotion, education and outreach, food delivery, financial management, and management information systems (MIS).

Amy Zimmerman, MPH, RD is the Chief of the DFH's Office for Children's Preventive Health Services (OCPHS). In this capacity, Ms. Zimmerman is responsible for the management and administration of the DFH's Childhood Lead Poisoning Prevention Program, Newborn Screening Program, and KIDSNET.

Deb Garneau, MA is the Chief of the DFH's Office for Families Raising Children with Special Health Care Needs (OFRCSHCN) //2004//. ***/2006/ In this capacity, Ms. Garneau is responsible for the management and administration of the DFH's Disability & Health Program, the Pediatric Practice Enhancement Project (PPEP), Pediatric Specialty Services, the Family Outreach Program (FOP), the Child Maltreatment Initiative, and other DFH supporting families raising CSHCN //2006//***.

/2005/ Jan Shedd, MEd, is the Chief of the DFH's Office for Family, Youth & School Success (OFYSS). In this capacity, Ms. Shedd is responsible for the management and administration of the DFH's Family Planning Program, Women's Health Screening & Referral Program (WHSRP), School-Based Health Center (SBHC) Program, Men 2B Program, Healthy Schools!/Healthy Kids!, Successful Start, community partnerships, youth development, and out-of-school time programming initiatives //2005//.

E. STATE AGENCY COORDINATION

/2004/ The DFH actively collaborates with other state agencies and on a variety of levels. The DFH is a major component of HEALTH, which reports directly to the Governor. Rhode Island General Law 42-72.5 (1991) created a Children's Cabinet to "address all issues, especially those that cross departmental lines, and relate to children's needs and services". From the start, HEALTH has been a full participant in the monthly open meetings and the many work groups and special projects of the Children's Cabinet //2004//. ***/2006/ As in the past, "Family Health in Rhode Island" will be on the Children's Cabinet agenda as part of the DFH's comprehensive conversation with all stakeholders before, during, and after the filing of the FY2006 Title V plan //2006//***.

/2004/ Other State Agencies

There are five other state agencies that provide various services to the state's maternal & child health populations, including children with special health care needs (CSHCN). These five agencies include the RI Department of Human Services (RIDHS), The RI Department of Mental Health, Retardation & Hospitals (MHRH), the RI Department of Children, Youth, & Families (RIDCYF), the RI Department of Corrections (RIDOC), and the RI Department of Education (RIDE). The DFH coordinates with these

five other departments on an ongoing basis //2004// ***/2006/ In FY2000, the DFH partnered with the RIDOC to expand Title X family planning services to women being discharged from prison. Currently, it has plans to expand the Men2B initiative to men who about to be discharged from prison.***

The DFH has a number of formal inter-agency agreements with the RIDHS related to the Medicaid Program. Existing Medicaid agreements with RIDHS include ones for Family Resource Counselors (FRCs), Early Periodic Screening, Diagnosis, & Treatment (EPSDT), and the Child Development Center (CDC) //2006//. /2004/ In addition, the DFH's OFRCSHCN worked closely with the RIDHS's Disability Determination Unit to develop a "welcome packet" for families with CSHCN that have applied for SSI benefits. DFH SBHC staff work closely with RIDHS and the RIte Care plans to increase enrollment and reimbursement in SBHC sites. The RIDHS supports Child Care Support Network (CCSN) activities and actively participates on the DFH's Healthy Child Care Rhode Island (HCCRI) Advisory Committee. The DFH also participates on the RIDHS's RIte Care Consumer Advisory Committee.

In addition to formal agreements, staff from the DFH provide consultation and professional expertise to the RIDHS, RIDE, RIDCYF, and RIMHRH in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions. The DFH also collaborates extensively with RIDHS to create a statewide infrastructure for addressing the problem of childhood lead poisoning among children with Medicaid in Rhode Island. RIDHS supports four regional certified lead safe centers, which provide lead poisoned children with Medicaid with comprehensive case management services and coordinated linkage to other services and supports. It is notable to point out that RIDHS covers replacement windows as a medically necessary service for lead poisoned children through Medicaid.
The DFH, through the OCSHCN, is working with RIDE to ensure an integrated educational system that serves CSHCN transitioning to adulthood (i.e. 21 years of age). In addition, the DFH is jointly managing the Healthy Schools!/Healthy Kids! initiative with RIDE. Health Schools!/Healthy Kids! Is a collaborative process that involves parents, legislators, schools, health care providers, community organizations, and state departments. The DFH participates on RIDE's Mental & Behavioral Health Workgroup, which is assessing mental and behavioral health services in schools and connections to other systems of care //2004//.

/2006/ The DFH is working with the RI School for the Deaf and RIDE to coordinate and maintain follow-up for infants identified with hearing loss, to conduct two research studies related to hearing loss, and to develop systems related to school-based hearing screening & follow-up. The DFH worked with the RIDCYF and other partners (i.e. Child Advocate's Office, the Attorney General's Office, the Medical Examiner's Office, Brown University, and Hasbro Children's Hospital) on the DFH's Child Maltreatment Initiative //2006//.

/2004/ The DFH also has a strong working relationship with the Rhode Island Department of Environmental Management (RIDEM) on two projects. First, the DFH's Childhood Lead Poisoning Prevention Program works with RIDEM to assure that public complaints about illegal exterior lead-based paint removal are addressed. This includes targeting high-risk areas, working with contractors who perform residential painting, and taking compliance action against non-compliant contractors and homeowners. Second, RIDEM assists the DFH's WIC Program in operating the Farmers Market Nutrition Program (FMNP). RIDEM liaisons with farmers and organized farmer's markets to ensure that sales of locally grown produce to program participants are in compliance with existing rules and regulations.

Legislative Initiatives

In addition, DFH staff participate on the Governor's Council on Mental Health and the Governor's Juvenile Justice Reform Task Force. Legislative initiatives that DFH staff participate in include the Permanent Legislative Commission on Traumatic Brain Injury (statewide commission advising on all aspects of traumatic brain injury), the Permanent Legislative Commission on Child Care (statewide

commission advising on all aspects of child care), and the RI Transition Council (statewide commission working on ensuring effective transitions for youth with disabilities who become adults). The DFH has also participates on numerous other shorter-tern legislative initiatives, including recent ones focusing on early intervention and childhood lead poisoning.

Other HEALTH Programs

With respect to internal collaboration, the DFH works closely with other HEALTH programs on an ongoing basis. Most notably, it has an ongoing partnership with the Division of Disease Prevention & Control (DDPC), which has responsibility for overseeing oral health activities, tobacco cessation, obesity prevention, primary care, injury control, genetics, women's cancer screening, women's health, and communicable disease activities. DFH staff participate on the DDPC's Oral Health Coordinating Team, the Genetics Core Team and its Genetics Advisory Committee (which has a Newborn Screening Sub-Committee), the Obesity Prevention Coalition, and the Internal Women's Health Workgroup. It participates with DDPC staff on the Northeast Injury Prevention Network. The DFH is also collaborating with the DDPC's STD program and state laboratory on a Chlamydia screening project //2004//. ***/2006/ The Chief of the DFH's Data & Evaluation Unit co-chairs an Interdepartmental Surveillance and Statistics Group with the DDCP and HEALTH's Office of Statistics to facilitate data/information/"best practices" sharing within HEALTH on data/epidemiology initiatives //2006//***.

/2004/ The DFH also has ongoing partnerships with HEALTH's laboratory, Division of Facilities Regulation, and Division of Environmental Health (DEH). Facilities Regulation provides comprehensive site reviews of licensed health care facilities, including hospitals and community-based health centers. The DEH provides comprehensive environmental lead inspections for significantly lead poisoned children and their families. The DFH also works closely with HEALTH's Office of Minority Health (OMH), which is a part of the Health Director's Office. The OMH has organized training for HEALTH staff, including DFH staff, on culturally competency //2004//. ***/2006/ In addition, the DFH works closely with the Office of Vital Records to coordinate data collection at maternity hospitals and to integrate birth certificate and death reports with KIDSNET and newborn screening systems //2006//***.

Private Organizations and Associations

/2004/ The DFH's partnerships with private, community-based organizations and associations are extensive. The following represents a summary of several of its major relationships.

Private Provider Community: Both the Medical Director and the Assistant Medical Director are active in professional provider organizations. In addition, the Medical Director is a member of the Primary Care Physicians' Advisory Committee. DFH staff have worked closely with the Rhode Chapters of the American Academy of Pediatrics, the Rhode Island Chapter of Family Practitioners, and the Rhode Chapter of the American Academy of Obstetricians and Gynecologists on a number of DFH initiatives, including the DFH's Women's Health Screening & Referral Program (WHSRP) and KIDSNET. The DFH's Newport CATCH initiative was originally supported through an American Academy of Pediatrics "medical homes" grant and is supported by the Rhode Island Chapter. DFH work closely with the Physicians' Committee for Breastfeeding in Rhode Island, which recently introduced and passed legislation promoting breastfeeding in the workplace //2004/.

Community Health Center Providers: A significant proportion of DFH investments support activities occurring in community health centers through out Rhode Island, including Family Resource Counselors (FRCS), WIC, Family Planning, Women's Health and Screening & Referral (WHSRP), and SBHCs. DFH work directly with individual community health centers on health center specific activities on an ongoing basis. The DFH also works with community health centers through the Rhode Island Health Center Association on larger policy issues impacting community health center services delivery.

Hospitals: The DFH has strong partnerships with several hospitals in Rhode Island. The Child Development Center (CDC) is a part of Rhode Island Hospital, and Memorial Hospital is a Title X site. The DFH supports Family Resource Counselors (FRCs) in St. Joseph Hospital, Memorial Hospital, Women & Infants Hospital, and Hasbro Children's Hospital. The DFH's Newborn Screening Programs work closely with Women & Infants Hospital. Hasbro Children's Hospital is collaborating with the DFH and other partners on the DFH's Child Maltreatment Initiative. Newport Hospital is collaborating with the DFH and other partners on the Newport County CATCH initiative. The DFH supports lead and immunization clinics for uninsured children in Rhode Island Hospital and St. Joseph Hospital //2004//. ***/2006/ The DFH's Birth Defects Program has been working closely with Hasbro Children's Hospital to improve case ascertainment. Representatives from these hospitals provide information, consultations and guidance; and several are members of the DFH's Birth Defects Advisory Council //2006//***.

/2004/ Visiting Nurse Associations (VNA): The DFH has strong partnerships with several VNA through the DFH's Family Outreach Program (FOP). FOP home visitors provide home assessments, connection to community services, and help with child development and parenting for almost one-third of all families with newborns each year //2004//. ***/2006/ FOP home visitors also serve as the follow-up mechanism for the DFH's Lead Poisoning and Immunization Programs. DFH personnel meet with FOP staff through the FOP Network, which is made up of FOP provider agencies. In addition, one VNA is a Title X family planning site. Another VNA provides newborn developmental risk assessment statewide and newborn blood spot screening follow-up through contracts with the DFH //2006//***. /2004/ VNAs also participate on the DFH's Birth Defects Advisory Council.

Child Care Support Network (CCSN): The DFH's HCCRI initiative works closely with the childcare provider community and families through the HCCRI Advisory Committee and CCSN. The CCSN is made up of a team of professionals who work with licensed center-based and home-based child care providers to improve the quality of care for all children in the following areas: health and safety, curriculum development, early literacy, CSHCN, child development, family involvement, and mental/behavioral health.

Family Voices Rhode Island: The OCSHC works closely with leadership from the Rhode Island Chapter of Family Voices on an ongoing basis. The Director of Family Voices meets regularly with the DFH's Medical Director and the Chief of the OCSHCN. The Director of Family Voices is a member of the OCSHCN's SSI Team. Family Voices RI is one of a few state Family Voices chapters to implement a Family-to-Family Information Center. In addition, the Director of Family Voices participated in the planning phase of the DFH's recent reorganization of the OCSHCN //2004//.

/2006/ Rhode Island Chapter of the March of Dimes (MOD): The DFH is collaborating with the MOD on three major initiatives. The first one focuses on ensuring that women (especially low-income women) in Rhode Island have access to folic acid education prior to becoming pregnant or early in pregnancy in order to prevent birth defects. A second is to expand the newborn screening panel in Rhode Island to meet the recommendations of an American College of Medical Genetics Report. The third focuses on working with the MOD and other key community partners to develop statewide initiatives to reduce prematurity in Rhode Island. In addition, the MOD is a member of the DFH's Birth Defects Advisory Council and the PRAMS Steering Committee //2006//.

/2004/ Healthy Mothers/Healthy Babies Coalition: The DDH participates in this statewide coalition dedicated to improving birth outcomes. Associated with the Rhode Island Chapter of the March of Dimes (MOD), members include state departments, community agencies, and providers. Healthy Mothers/Healthy Babies participates on the DFH's PRAMS Steering committee.

Rhode Island Parent Information Network (RIPIN): RIPIN is a statewide, non-profit agency that provides information, training, support, and advocacy to parents seeking help for their children in Rhode Island. RIPIN provides parenting strategies and information about child development, school

readiness, literacy, discipline, violence prevention, disabilities, special education, transitions, and health-related issues. The DFH refers individuals who call the DFH's Family Health Information Line to RIPIN. In addition, RIPIN provides training and technical assistance to the DFH's Parent Consultant program on an ongoing basis.

Rhode Island KIDS COUNT: This children's policy organization provides information on child well-being and stimulates state dialogue on children's issues. Each year, Rhode Island KIDS COUNT publishes a KIDS COUNT Factbook, which provides a detailed community-by-community picture of the condition of children in Rhode Island. The DFH provides KIDS COUNT with a significant proportion of data utilized in the fact book, including data for childhood lead poisoning, WIC, CSHCN, breastfeeding, prenatal care, low birth weight infants, infant mortality, and births to teens. KIDS COUNT is also a member of the DFH's Birth Defects Advisory Council.

Covering Kids Rhode Island: Funded by a Robert Wood Johnson grant, the purpose of Covering Kids is to increase access among children in Rhode Island to Medicaid. Covering Kids accomplishes this goal by helping local communities develop and implementing strategies to enroll potentially eligible children and their families into Medicaid (including RIte Care & RIte Share. The DFH works closely with Covering Kids through the DFH's FRC Program and community systems development initiatives, including Ready to Learn Providence (RLP) and Newport County CATCH.

Childhood Lead Action Project (CLAP): This non-profit agency is the only advocacy agency in Rhode Island solely dedicated to addressing the problem of childhood lead poisoning in Rhode Island. CLAP is a member of the DFH's Childhood Lead Poisoning Prevention Advisory Committee.

Rhode Island Public Health Association (RIPHA): The RIPHA was formed to organize and activate private sector professionals interested in the advancement of public health in Rhode Island. DFH personnel participate in RIPHA conferences and workshops //2004//. ***/2006/ The DFH participated in the development of a genetics brochure with the RIPHA //2006//***.

/2004/ Youth In Action (YIA): The DFH is partnering with the youth-led, community-based organization YIA to provide family planning outreach, education, and referral services to culturally diverse young men living in the Southside of Providence. Young men in need of clinical family planning services are referred to a Title X site.

Rhode Island Breastfeeding Coalition (RIBC) is a coalition of community organizations and groups dedicated to supporting and promoting breastfeeding in Rhode Island. Members include lactation consultants from local birthing hospitals, physicians, and other health care professionals. The RIBC organizing statewide breastfeeding events such as "World Breastfeeding Month" and currently serves as the Advisory Board for HEATH's Office of women's Health (OWH) national breastfeeding awareness campaign grant.

Rhode Island Food Dealers Association: This professional association acts as the liaison between the DFH's WIC Program and WIC venders throughout the state and assists the DFH coordinate WIC activities targeting WIC venders throughout the state //2004//.

/2006/ Rhode Island Hearing Screening Assessment Program (RIHAP): RIHAP at Women & Infants Hospital provides screening, support and follow-up for children with hearing impairment identified through a contract with the DFH's Newborn Screening Program. DFH personnel participate on RIHAP's Hearing Screening and Follow-Up committees on an ongoing basis. The DFH is collaborating with RIHAP on two federal grant initiatives (CDC & HRSA) related to newborn hearing screening and follow-up, one of which includes two research components //2006//.

Immunization Action Plan Coalition: The coalition consists of DFH staff, community-based agencies, civic organizations, medical care providers (including community health centers), schools, Head Starts, hospitals, and health insurance plans. The purpose of the coalition is to share strategies and

develop plans for improving utilization rates //2004//.

/2006/ Rhode Island School Nurse Teachers Association: The DFH's Immunization Program partners with this group to provide input and feedback for the annual school nurse teachers conference. This conference is an educational opportunity for school nurses from all public and private schools, Head Start and Early Head Start agencies, and child care providers //2006//.

Advisory Committees

/2004/ The DFH has established advisory and work groups for several of its programs made up of DFH staff and professionals. Most also include consumer representation. Current DFH advisory and work groups include the Family Planning Advisory Council (FPAC), the Family Planning Program Information & Education (I & E) Committee, the
Women's Health Screening & Referral Program (WHSRP) Work Steering Committee, the School Based Health Center Network, the Men 2B Program Network, the
Family Resource Counselor (FRC) Network, the Healthy Child Care Rhode Island (HCCRI) Advisory Committee, the Successful Start Steering Committee, the Childhood Lead Poisoning Prevention Advisory Committee, the Birth Defects Advisory Council, the
Rhode Island PRAMS Steering Committee, and the WIC Local Outreach Committee, the Newborn Screening Task Force.

For a detailed summary of the DFH's relationships with other entities, please refer to the attachment /***/2006//.***

F. HEALTH SYSTEMS CAPACITY INDICATORS

/2006/ The Division of Family Health (DFH) utilizes nine MCH health systems capacity indicators to facilitate statewide changes that are most likely to improve the health and well-being of Rhode Island's MCH population. It also utilizes these health systems capacity indicators to monitor its progress in improving or maintaining the MCH service delivery infrastructure in Rhode Island.

Health Systems Capacity Indicators

#01: The rate of children hospitalized for asthma (per 10,000 children less than five years of age. Asthma is one of the few medical problems that may be used to measure the extent to which children are receiving quality disease preventive care and health promotion education. Access to and utilization of appropriate medical care can often prevent severe episodes of asthma. Increase asthma hospitalization rates may be a consequence of inadequate outpatient management and diminished access to a "medical home".

In Rhode Island, the asthma hospitalization rate appears to have stabilized in FY2004 after increasing significantly during the previous four years. In FY2000, it was 60.3; in FY2001, it was 65.3; in FY2002, it was 84.6; in FY2003, it was 98.8 (provisional); and in FY2004, it was 98.0 (provisional). These increases reflect national trends. About 50% of the children who are hospitalized for asthma in Rhode Island live in one the state's culturally diverse, older, urban, "core" communities.

HEALTH, in collaboration with the American Lung Association of Rhode Island (ALARI) and other community partners in the Asthma Control Coalition of Rhode Island, are working to implement a comprehensive 5-year statewide plan for asthma control (2002-2007). The plan will include comprehensive community-based strategies for managing pediatric asthma and will

includes a focus on reducing health disparities.

#02: The percentage of Medicaid enrollees whose age is less than one year who received at least one periodic screen. The EPSDT Program is a national initiative to provide quality comprehensive services to all Medicaid-eligible children. Increasing access to comprehensive, family-centered, community-based, culturally competent care for the medically underserved population of the state is a first step toward establishing a "medical home" and a regular source of care.

In Rhode Island in FY2000, this percentage was 91.7%; in FY2001, it was 92.6%; in FY2002, it was 88.4%; in FY2003, it was 91.4%; and in FY2004, it was 93.2% The FY2003 and FY2004 rates are up a bit from the previous year's rate (FY2002), but still within normal limits of annual variations. It is important to point out that there were considerably more infants in FY2003 and FY2004 than in previous years due to increased births and increased enrollment in RIte Care.

#03: The percentage of SCHIP enrollees whose age is less than one year who received at least one periodic screen. Not applicable, since SCHIP enrollees in Rhode Island are eight years old and older. Medicaid-enrolled children, less than one year of age, are covered by Medicaid as opposed to SCHIP (see above).

#04: The percentage of women (15-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index. Adequate prenatal is an effective intervention that improves pregnancy outcomes, including reduces infant mortality. In Rhode Island, this percentage went down in FY2004 as compared to previous years. In FY2000, it was 87.2%; in FY2001, it was 87.3%; in FY2002, it was 86.8%; in FY2003, it was 87.9% (provisional); and in FY2004, it was 83.9% (provisional).

#05: Comparison of health systems capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the state. Adverse health outcomes disproportionately affect the poor. Using birth certificate data, the percentages of low birth weight infants (< 2,500 grams) for Medicaid, Non-Medicaid, and all MCH populations in the state in FY2003 were higher for Medicaid populations (9.6%) and all MCH populations (8.6%) than it was for Non-Medicaid populations (8.0%).

Using birth certificate data, the percentages of infant deaths per 1,000 live births in FY2003 was higher for Medicaid populations at 9.0% as compared to Non-Medicaid populations (4.7%) and all MCH populations (6.7%). Using birth certificate data, the percentage of infants born to pregnant women receiving care in the first trimester in FY2003 was lower for Medicaid populations at 83.5% as compared to Non-Medicaid populations (95%) and all MCH populations (90.8%).

Using birth certificate data, the percentage of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% of the Kotelchuck Index) in FY2003 lower for Medicaid populations at 81.5% as compared to Non-Medicaid populations (91.3%) and all MCH populations (87.9%).

#06: The percent of poverty level for eligibility in the state's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women. Infants (0-1) qualify for Medicaid if < 250% of the federal poverty level (FPL). SCHIP does not include infants. Children (1-18) qualify or Medicaid if <250% of the FPL. Children (1-18) qualify for SCHIP if <250% of the FPL. Pregnant/postpartum women qualify for Medicaid if < 185% of the FPL. Pregnant/postpartum women qualify for SCHIP if 185-250% of the FPL. Families with incomes >150% of the FPL are subject to a family partial premium. Threshold increases to 185% for families consisting only of pregnant women and infant(s).

#07: The percent of EPSDT eligible children aged 6-9 years who have received any dental

services during the year. Dental caries is perhaps the single most prevalent disease known. In Rhode Island, this percentage appears to be going up slightly over the past four years. In FY2000, it was 48.9%; in FY2001, it was 55.9%; in FY2002, it was 54.6%; in FY2003, it was 54.1%; and in FY2004, it was 56.1%. As the RI Department of Human Services (RIDHS) continues to work to improve the existing state infrastructure for providing dental services for Medicaid eligible populations, it is expected that this percentages will rise over time.

#08: The percentage of SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN Program. This percentage continues to decrease as more and more CSHCN (including SSI beneficiaries less than 16 years old receiving rehabilitative services) are transitioned to services provided through the Rhode Island Department of Human Services (RIDHS). In FY2000, it was 20.1%; in FY2001, it was 15.6%; in FY2002, it was 10.2%; in FY2003, it was 9.1%; and in FY2004, it was 8.1% (provisional).

#09(A): The ability of states to assure that the MCH Program and Title V agency have access to policy and program relevant information and data. The DFH obtains electronic data through annual linkage of infant birth and death certificates, annual linkage of birth records and WIC eligibility files, and annual linkage of birth records and newborn screening files. It also has the ability to obtain data for program planning and policy purposes in a timely manner from the following registries/surveys: hospital discharge data for at least 90% of in-state discharges, PRAMS, and Birth Defects Surveillance. It does not have the ability to obtain annual data linking birth certificates and Medicaid eligibility or paid claims files, electronically or otherwise, at this time.

#09(B): The ability of states to determine the percentage of adolescents in the grades 9-12 who report using tobacco products in the last month. HEALTH participates in the Youth Risk Behavior Survey (YRBS) and the DFH has direct access to the YRBS database for analysis. The state also participates in the School Accountability for Learning and Teaching (SALT) Survey and the Youth Tobacco Survey (which began in 2001 and is conducted every two years). The DFH does not have direct access to either the SALT or Youth Tobacco Survey databases for analysis.

#09(C): The ability of states to determine the percentage of children who are obese or overweight. The DFH participates in the YRBS and the RI Health Interview Survey (RIHIS) and the DFH has direct access to the YRBS & RIHIS databases for analysis. It also collects data on childhood obesity through the DFH's WIC Program and Immunization Program. The Immunization Program began collecting height and weight information for Kindergarteners beginning in FY2002. The state does not participate in the Pediatric Nutrition Surveillance System (PedNSS) //2006//.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

/2006/ Results from the statewide needs assessment, state and national performance measures, capacity indicators, and community-stakeholder provide a comprehensive picture of the MCH needs in Rhode Island. From this combination of quantitative and qualitative information, the DFH identified 10 priorities in 1999. Linked to these priorities are state and national performance measures. Together, the priorities represent each of the four levels of MCH services and all MCH population groups. Because the priorities relate to more than one level of services, the service level assigned to the priority was determined to by its performance measure.

For example, the state performance measure that focuses on early prenatal care for select population groups (SPM #4) and the national performance measure that focuses on the percent of infants born to pregnant women receiving prenatal care in the first trimester (NPM #18) address the DFH priority "to reduce and manage pregnancy risks" has been determined to be an infrastructure building activity since assuring that comprehensive health care systems are in place for pregnant women will hopefully lead to a reduction in pregnancy risks, including late entry into prenatal care. However, SPM #4 and NPM #18 also reflect other levels of service. For example, the DFH's Women's Health Screening & Referral Program (WHSRP) is a DFH-supported activity associated with SPM #4 and NPM #18. Since the WHSRP directly identifies and addresses pregnancy risks in women early in pregnancy, including issues related to late entry into prenatal care, it could also be considered to be a direct service. In fact, the capacity to address significant public health challenges at several service levels in an integrated way is the special mandate of Title V and the DFH is proud of its coordinated, leveraged, and evaluated investments in community care for all children and their families in Rhode Island.

For FY2006, the DFH developed new priorities and state performance measures based on its comprehensive needs assessment conducted and the community input received in FY2005. The DFH's new state performance measures (and their affiliated priorities) are as follows:

1. The percentage of PRAMS respondents who report a diagnosis of depression before, during, or after pregnancy (Addresses priority #1: To improve maternal health through the reproductive lifespan).
2. The percentage of children ages 2-5 years with a Body Mass Index BMI greater than the 95th percentile (Addresses priority #2: To promote healthy lifestyles and healthy weights for all Rhode Islanders).
3. The percentage of families with at-risk newborns who receive a home visit (Addresses priority #3: To engage, empower, support, and inform families).
4. The percentage of children less than six years old with blood lead levels greater than or equal to 10 mg/dl who reside in the state's core urban cities (Addresses priority #4: To support safe and healthy environments for children and families).
5. The percentage of middle and high school age youth who receive a behavioral health services among youth who receive any school-based health service (Addresses priority #5: To address the social, emotional, and behavioral health needs of the MCH population).
6. (a) The ratio of prematurity rate for Black infants to the prematurity rate for White infants (Addresses priority #6: To improve pregnancy outcomes).
6. (b) The percentage of PRAMS respondents who report taking a multi-vitamin with folic acid prior to pregnancy (Addresses priority #6: to improve pregnancy outcomes).
7. The percentage of children (who have had at least one immunization) with complete immunization series (4:3:1:3) and at least one lead screening by age 2 years (Addresses priority #7: To ensure a medical home for all Rhode Island families).
8. The percentage of newborns who live in neighborhoods with MCH community systems building partnerships (Addresses priority #8: To enhance MCH programs).

9. The percentage of licensed childcare providers with on-site health consultants (Addresses priority #9: To promote healthy human development in children, adolescents, and families).

The DFH's priorities and performance measures builds upon families' strengths and assets. New research in public health promotion is beginning to document how building a population's strengths and social capital can promote positive outcomes and avoid or mitigate negative ones. In addition, asset-based community development activities throughout the country have also shown how empowerment, resiliency, and the ability of communities to build on their asset base can contribute to achieving desired changes.
The asset-based measurement approach can complement more traditional measures of needs, morbidity, and remediation by highlighting capacity-building strategies to promote a population's strengths and minimize deficits. For instance, family resource centers (FRCs) can be effective multi-service delivery platforms with high degrees of family participation, trust and satisfaction. Measuring the prevalence of FRCs, identifying common elements of and services offered by an FRC, and gleaning best practices from the child and family outcomes related to use of an FRC can provide incentives and strategies to develop FRCs in new and existing service delivery models.

The DFH will utilize the FY2007 Title V MCH application to discuss how its new priorities, national performance measures, new state performance measures, and program activities relate to the four levels of MCH services and all MCH population groups in detail. In this application (FY2006), the DFH will discuss and assess its performance with respect to addressing the state priorities, state performance measures, and national performance measures originally adopted and/or developed in 1999 (with minor modifications made in subsequent years) by the DFH //2006//.

B. STATE PRIORITIES

/2004/ State Performance Measures

This section looks at the relationship between the DFH's state priorities and its state performance measures by the four levels of MCH services (direct health, enabling, population-based, and infrastructure building services) //2004//. ***/2006/ This discussion pertains to the state priorities and state performance measures that were originally developed (with minor modifications made in subsequent years) by the DFH in 1999 //2006//***.

/2004/ Direct Health Care Services

The DFH has identified two priority areas that relate to direct services: "improve the health, safety, and optimal development of adolescents" and "assure access to appropriate services during periods of transition for CSHCN and other children". These priorities are derived from the DFH's needs assessment and health status indicators.

The corresponding state performance measures for these two priorities are: "the percentage of students in schools with SBHCs who are enrolled in SBHCs (SPM #2)" and "the percentage of children in the EI Program with IFSPs discharged to Special Education for whom an IEP is developed (SPM #7)", respectively.

Rhode Island survey data and vital statistics records reveal that teens are taking risk in the areas of tobacco, alcohol and drugs, sexual intercourse, and other behaviors that might result in unintentional or intentional injuries or deaths. The DFH's SBHCs are an important resource for addressing these risks. The number of children enrolled in EI has been rising and nearly half of the children enrolled in EI transition to Special Education. The transition of these children into Special Education is critical.

Enabling Services

The DFH has identified two priority areas that relate to enabling services: "improve the nutritional status of children, youth, and their families" and "assure that eligible individuals participate in MCH programs through intensive outreach efforts". The corresponding state performance measures for these priorities are "the percentage of infants who are underweight and the percentage of children who are underweight or overweight in the DFH's WIC Program (SPM #8)" and the percentage of at risk newborns who receive a home visit from the DFH's Family Outreach Program (FOP) during the early newborn period (SPM #9)", respectively. Childhood obesity continues to be a significant health risk in Rhode Island. One in ten children enrolled in the DFH's WIC Program are overweight. In addition, not all those who are eligible for MCH services are enrolled. Although nearly half of the state's newborns are determined to be at-risk for developmental delays, some families refuse DFH home visiting services.

Population-Based Services

The DFH has identified three priority areas that relate to population-based services: "provide education, support, and environmental risk reduction to families"; "strengthen partnerships between schools, neighborhood and home"; and "increase community/family feedback/involvement regarding DFH program services and policies". The corresponding state performance measures for these three priorities are: "the percentage of 9th graders who are expected to graduate from high school (SPM #6)", "the percentage of children less than 6 years old in at-risk population subgroups with lead levels greater than or equal to 10 ug/dl (SPM #5)", and "the number of completed family surveys (SPM #10)", respectively. Although the proportion of children who have elevated lead levels is decreasing, still nearly one in ten children under the age of six have elevated lead levels in Rhode Island. Quality education is linked to school success. High school dropouts are more likely to be unemployed, to be on public assisting, and to earn less money than high school graduates. A significant proportion of students drop out of high school in Rhode Island. By strengthening partnerships between school, neighborhood, and home, long term improvements in the state's high school graduation rate may be achieved. In addition, community and family input is key to understanding the MCH needs and priorities of Rhode Islanders.

Infrastructure Building Services

The DFH has identified three priority areas that relate to infrastructure building services: "assure the health, safety, and optimal development of children in child care settings", "expand access to genetics services during the preconception and prenatal periods", and "reduce and manage pregnancy risks". The corresponding state performance measures for these three priorities are: "the number and percentage of children > 18 months in child care who are up-to-date on their immunizations (SPM #1)", "the proportion of women who receive an AFP test (SPM #3)", and, as previously noted, "the percentage of pregnant women who receive prenatal care in the first trimester by population subgroups (SPM #4)." Studies have shown that quality child care programs are linked to school readiness. Children in these settings are cared for in environments that protect their health and safety. In addition, ensuring access to genetics services, including AFP testing, can lead to a decrease in birth defects.

Activities that correspond to the DFH's priorities and state performance measures are included in Section IV (D) in this application.

National Performance Measures

The DFH has described the relationship of the state's priority needs and its state performance measures by the four levels of MCH services (direct health, enabling, population-based, infrastructure building) above. The following represents discussion of the relationship between the state's priority needs and the national performance measures by the four levels of the pyramid. Again, the service level assigned to each priority was determined by its performance measure //2004//. ***/2006/ This discussion pertains to the state priorities that were originally developed (with minor***

modifications made in subsequent years) by the DFH in 1999 and the federal MCH Program's existing national performance measures //2006//.

/2004/ Direct Health Care Services

The DFH has identified two priority areas that relate to direct services: "improve the health, safety, and optimal development of adolescents" and "assure access to appropriate services during periods of transition for CSHCN and other children." The corresponding national performance measures that relate to these two priorities are as follows:

1. Improve the health, safety, and optimal development of adolescents: the birth rate per 1,000 for teenagers aged 15 through 17 years (NPM #8) and the rate per 1000,000 of suicide deaths among youth ages 15-19 (NPM #16).

2. Assure access to appropriate services during periods of transition for CSHCN and other children: the percentage of youth with CSHCN who received the services necessary to make transitions to all aspects of adult health (NPM #6).

Enabling Services

The DFH has identified two priority areas that relate to enabling services: "improve the nutritional status of children, youth, and their families" and "assure that eligible families participate in MCH programs through intensive outreach efforts." The corresponding national performance measures that relate to these two priorities are as follows:

1. Improve the nutritional status of children, youth, and their families: the percentage of mothers who breastfeed their infants at hospital discharge (NPM #11).

2. Assure that eligible families participate in MCH programs through intensive outreach efforts: the percentage of infants who are screened for conditions mandated by their state-sponsored newborn screening program and receive appropriate follow-up and referral (NPM #1), the percentage of CSHCN whose families have adequate private and/or public insurance to pay for the services they need (NPM #4), the percentage of newborns who have been screened for hearing prior to hospital discharge (NPM #12), percent of children without health insurance (NPM #13), and the percentage of potentially Medicaid children who have received a services paid for by Medicaid (NPM #14).

Population-Based Services

The DFH has identified three priority areas that relate to population-based services: "provide education, support, and environmental risk reduction to families", strengthening partnerships between schools, neighborhood and home", and "increase community/family feedback regarding DFH program services and policies." The corresponding national performance measures that relate to these three priorities are as follows:

1. Provide education, support, and environmental risk reduction to families: the rate of deaths to children ages 14 years and younger caused by motor vehicle crashes per 100,000 (NPM # 10).

2. Strengthening partnerships between schools, neighborhood and home: the percentage of CSHCN ages 0-18 who receive coordinated, ongoing, comprehensive care within a medical home (NPM #3) and the percentage of third grad children who have received protective sealants on at least one permanent molar tooth (NPM #9).

3. Increase community/family feedback regarding DFH program services and policies: the percentage of CSHCN ages 0-18 whose families partner in decision-making at all levels and are satisfied with the services they receive (NPM #2) and the percentage of CSHCN ages 0-18 whose families report that the community-based services systems are organized so that they can use them (NPM #5).

Infrastructure Building Services

The DDH has identified three priority areas that relate to infrastructure building services: "assure the health, safety, and optimal development of children in child care settings", expand access to genetics services during the preconception and prenatal periods", and "reduce and manage pregnancy risks". The corresponding national performance measures that relate to these three priorities are as follows:

1. Assure the health, safety, and optimal development of children in child care settings: the percentage of 19-25 month olds who have received full schedule of age-appropriate immunizations (NPM #7).

2. Reduce and manage pregnancy risks: the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (NPM #17) and the percentage of infants born to pregnant women receiving prenatal care in the first trimester (NPM #18).

3. Expand access to genetics services during the preconception and prenatal periods: the percentage of very low birth weight infants among all live births (NPM #15)

Activities that correspond to the DFH's priorities and the national performance measures are included in Section IV (C) in this application //2004//.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				99.2	99.2
Annual Indicator			100.0	100.0	100.0
Numerator			21	26	22
Denominator			21	26	22
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	99.5	99.5	99.6	99.6

Notes - 2002

Data reported are for occurrence births.
There are (5) cases for non-sickling hemoglobinopathies not yet confirmed. Health is continuing to follow these cases.

Notes - 2003

2003: No treatment was needed for one fo the PKU cases.

a. Last Year's Accomplishments

/2005/ Screening programs for newborns have proven to be cost effective and successful and have been shown to prevent mortality and morbidity //2005//. ***/2006/ The DFH's Newborn Screening Program continued to provide universal newborn screening for 9 inherited conditions, hearing impairment, and developmental risks (including socio-economic risks).***

The DFH continued to assure that newborns identified through the DFH's newborn screening process received appropriate follow-up care through the DFH's Family Outreach Program (FOP), which includes linkage to the Early Intervention (EI) Program. In addition, the DFH's culturally diverse FOP home visitors provided home visiting services to families who are difficult to reach.

The DFH's Newborn Screening Program successfully integrated newborn screening laboratory data with vital records through KIDSNET. This permitted the implementation of a valuable CQI report of infants over 6 days of age with no evidence of blood spot specimen at the laboratory. In addition to identifying true missed cases, several system quality issues have been identified and addressed.

The DFH hosted a site visit of team experts from the National Newborn Screening and Genetics Resource Center for the purpose of reviewing the program and making recommendations regarding strengths and weaknesses. A report from the visit is forthcoming.

Based on the American College of Medical Genetics report, the Newborn Screening Advisory Committee recommended expanding the panel of conditions screened to include 28 core conditions outlined in the report. The Genetics Screening Advisory Committee and the Director of Health accepted this recommendation. Initial steps toward regulatory, budgetary, and system changes needed to implement the expansion have begun.

A final report on a cost analysis of newborn screening in Rhode Island, including costs of expansion, was completed. The report looks at actual costs of screening, follow-up, diagnosis, treatment, and information systems. It will be used as a basis for recommending a fee increase.

The DFH's Newborn Screening Program collaborated with the DFH's Communications Unit on a process for developing integrated culturally and linguistically appropriate informing brochures (prenatal, perinatal, and postnatal) for families that includes bloodspot, hearing, developmental risk, home visiting, and birth defects surveillance, and KIDSNET. Stakeholder surveys and focus groups with parents were completed. Draft brochures were developed and designed.

RI PRAMS surveyed approximately 2,000 women 2-4 months after they delivered babies and asked whether respondents were aware that babies are tested in the hospital for conditions that run in the family, such as sickle cell disease and PKU. This is an ongoing activity //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Assures universal newborn screening, diagnosis, and intervention for 9 inherited conditions.				X
2. Is plannning for the expansion of the panel of newborn screening conditions to include 28 conditions, as recommended in the ACMG report.				X
3. Assures that newborns identified through the newborn screening process are referred to Family Outreach Program (FOP) for home visiting services.	X			
4. Assures a mechanism for ensuring that "hard-to-reach families" with a risk positive newborn identified through the newborn screening process are reached through culturally diverse FOP home visitors.	X			
5. Is working on pre-populating the newborn screening laboratory database with electronic birth certificate data.				X
6. Administers a CQI plan for bloodspot screening, which includes data and systems level quality issues.				X
7. Developed integrated prenatal, perinatal, and post-natal informing brochures for providers and families, based on survey and focus group results with culturally diverse families.			X	
8. Made modifications to the draft integrated informing brochures, based on field testing, prior to their translation into Spanish.			X	
9. Is developing a distribution plan for the disemmination of the integrated informing brochures once they are finalized.			X	
10. Continues to survey women who recently gave birth through PRAMS, which includes questions related to newborn screening.				X

b. Current Activities

/2005/ The DFH continues to assure early screening, diagnosis, and intervention for all newborns with special health care needs. Specifically, the DFH provides universal newborn screening for 9 inherited conditions, hearing impairment, and developmental risks (including socio-economic risks) //2005//.

/2006/ The DFH assures that newborns identified through the DFH's newborn screening process receive appropriate follow-up care through the DFH's Family Outreach Program (FOP), which includes linkage to the Early Intervention (EI) Program. In addition, the DFH's culturally diverse FOP home visitors provide home visiting services to families who are difficult to reach.

A CQI Plan for bloodspot newborn screening is ongoing. The CQI Plan includes data and system level quality issues. A Policy and Procedure Manual has been drafted. Most of the policies and procedures have been through external review by the Newborn Screening Advisory Committee and other partners and have been adopted. Specifications for pre-populating newborn screening laboratory and hearing databases with electronic birth certificate data were developed and entered into a programming queue.

The DFH continues to plan for the expansion of the panel of conditions to include 28 conditions as recommended in the American College of Medical Genetics report. Specifically, the DFH continues to work toward implementing the regulatory, budgetary, and system changes needed to implement the expansion.

Informing brochures (prenatal, perinatal, postnatal) have been developed by the DFH, based on survey and focus group results with families //2006//. /2005/ An integrated informing approach was used and includes bloodspot, hearing, developmental risk, home

visiting, birth defects surveillance, and KIDSNET. The DFH will develop a strategy to distribute the informing brochures to prenatal, hospital, and pediatric health providers. The goal is to assure that the providers understand their role in the newborn screening informing process, routinely give materials to their patients, and answer questions from their patients //2005//. ***/2006/ Prototypes of the draft brochures were field tested. Modifications were made prior to their translation into Spanish.***

RI PRAMS surveyed approximately 2,000 women who delivered babies during FY2004. During FY2005, RI PRAMS received weighted data from the CDC that represent women who gave birth during 2003. Combined weighted data for 2002 and 2003 indicate that 73.7% of the respondents were aware that babies are tested in the hospital for genetic conditions. For non-Hispanics, the rate was 77.39% and only 49.22% for Hispanics. The overall rate was down slightly form the previous year's rate of 74.1%. PRAMS will be used as a measure to monitor the impact of the new informing materials, including the impact of Spanish translations, once they are produced and distributed //2006//.

c. Plan for the Coming Year

/2006/ The DFH's will continue to provide universal newborn screening for inherited conditions, hearing impairment, and developmental risks (including socio-economic risks). The DFH will continue to assure that newborns identified through the DFH's newborn screening process receive appropriate follow-up care through the DFH's Family Outreach Program (FOP), which includes linkage to the Early Intervention (EI) Program. In addition, the DFH's culturally diverse FOP home visitors will continue to provide home visiting services to families who are difficult to reach.

In FY2006, programming to pre-populate newborn screening laboratory and hearing databases with electronic birth certificate data system will be completed. Newborn screening results will continue to be sent to KIDSNET so that newborns not screened will be identified and remedial action taken at six days //2006//. /2005/ Hepatitis B data will be transferred daily to an ACCESS database to facilitate tracking and follow-up of infants born to Hepatitis B positive mothers //2005//.

/2006/ Regulatory, budgetary, information, and medical care system changes will be made in order to implement expansion of blood spot screening from 9 to 28 conditions by July 1, 2006. A request for proposals for laboratory services will be issued in FY2006.

The DFH's Newborn Screening Program will continue to work to ensure that newborns with a confirmed diagnosis are reported to the DFH's Birth Defects Program //2006//. /2005/ The DFH will address data and system level quality issues as outlined in the DFH's CQI Bloodspot Plan as appropriate, including meeting with each hospital to review data and work toward selected improvements //2005//.

/2006/ In FY2006, the Newborn Screening Advisory Committee and other key partners will finalize the policy and procedure manual and then disseminate it to relevant partners throughout the state.

Newborn screening informing materials will be printed and distributed to prenatal, hospital, and pediatric health care providers. KIDSNET provider relations staff and the WIC outreach unit will participate in the distribution process for the prenatal and post natal materials //2006//.

Maternal awareness of newborn screening will continue to be monitored through RI PRAMS. Previous PRAMS survey results will be utilized as baseline data (before and after the

implementation of the informing process) ***//2006//.***

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				68.6	68.6
Annual Indicator			68.6	68.6	68.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	68.6	70	70	70	70

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

2003: SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

/2006/ The DFH continued to work to increase the number of families with CSHCN who partner in decision-making and are satisfied with the services they receive. The DFH's Office for Families Raising CSHCN (OFRCSHCN) continued to take a lead role in implementing the DFH's activities in this area.

In FY2004, the DFH's Complete Care Notebook was in the development process through the OFRCSHCN. The Complete Care Notebook was developed in response to requests from families of CSHCN for a portable organizer to record and file their child's important health information, from birth through adulthood. One of the main stressors for families is the need to have detailed heath care information readily available for the numerous professionals and service providers involved in their child's care. Having a notebook to

categorically record and organize their child's emergency information, health history, health tracking, daily routine, care providers etc. is a significant tool to assist families. The Complete Care Notebook also provides families with a community and state resource guide.

The OFRCSHCN continued to support the activities of the SSI Team, which was created in 1994 to help address the needs of children eligible for SSI and their families. The SSI Team includes the OFRCSHCN parent consultant and the Director of the Rhode Island Chapter of Family Voices as members. In FY2004, the OFRCSHCN worked with the RI Department of Human Services (RIDHS) and other partners to develop a "welcome packet" for families who have applied for SSI benefits. The "welcome packet" includes linguistically and culturally appropriate materials on a variety of topics including, but not limited to, CEDARR, Family Voices, & the RI Parent Information Network (RIPIN). Members of the SSI team visited each SSA Office in RI to train staff on local resources and deliver Family Voices Resources Guides.

The DFH's Healthy Child Care Rhode Island Initiative (HCCRI) worked with families to ensure that CSHCN have adequate access to childcare in a "natural setting". There is a shortage of childcare slots in "natural settings" for CSHCN in Rhode Island. HCCRI worked with the DFH's OFRCSHCN, RIPIN, the Child Care Support Network (CCSN), the HCCRI Advisory Board, and DFH parent consultants to provide training, technical assistance, and information to child care providers to help them to better accommodate CSHCN in child care. HCCRI continued to include parents with CSHCN on the HCCRI Advisory Board to assure that the identification of resources for this population remains a priority.

The DFH's Data & Evaluation Unit, in collaboration with the OFRCSHCN, continued to analyze and disseminate data from the National Survey of CSHCN. In addition, the DFH's "Medical Homes" Work Group developed measures of family satisfaction with services and decision-making //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Completed and distributed a Complete Care Notebook for families with CSHCN at the request of families with CSHCN.		X		
2. Continues to support the activities of the SSI Team, which developed a "welcome packet" for families of CSHCN who have applied for SSI benefits.		X		
3. Supports parent consultants at the Child Development Center (CDC), which provides comprehensive medical services to medically complex CSHCN.				X
4. Supports parent consultants at the hospital-based Community Asthma Program (CAP) and the community-based Pediatric Practice Enhancement Project (PPEP).				X
5. Is in the process of placing a parent consultant at the pediatric intensive care unit (PICU) at Hasbro Children's Hospital.				X
6. Continues to provide child care provers with training, TA, and information on how to better accomodate CSHCN in child care settings.		X		
7. Continues to include parents of CSHCN on the Healthy Child Care				

Rhode Island Initiative (HCCRI) Advisory Board.				X
8. Published findings from the 2001 National Survey of CSHNC.			X	
9. Co-sponsored a statewide CSHCN conference on "medical homes" with the Rhode Island Parent Information Network (RIPIN) and Family Voices Rhode Island.			X	
10.				

b. Current Activities

/2005/ The DFH continues to work to increase the number of families with CSHCN who partner in decision-making and are satisfied with the services they receive //2005//. ***/2006/ In FY2005, the Complete Care Notebook was printed and distributed to community programs that service large populations of CSHCN throughout the state. The notebooks are provided to families through parent consultants who provide support and assistance to families. The parent consultants were provided with training on the utilization of the notebooks through the OFRCSHCN. The notebooks have been exceptionally well received by community programs and families as perceived as a long over-due necessary tool to assist and support families raising CSHCNs //2006//***.

/2005/ The OFRCSHCN continues to support the activities of the SSI Team. In FY2004, the OFRCSHCN worked with the RI Department of Human Services (RIDHS) and other partners to develop a "welcome packet" for families who have applied for SSI benefits //2005//. ***/2006/ In FY 2005, the SSI Team provided intensive training/resources and fully partnered with the SSA Offices in Rhode Island and neighboring states//2006//***.

/2005/ There are now two DFH parent consultants working at the CDC, one of which is funded by the DFH. The CDC provides medical services (including care coordination) to medically complex CSHCN //2005//. ***/2006/ The two parent consultants are assisting families with navigating the process of specialty evaluation and services delivery and assisting families with resources upon diagnosis. The parent consultants also provide in-service training to professionals at the CDC concerning family-centered practice.***

The OFRCSHCN strategically places parent consultants throughout the special needs service delivery system, including the Community Asthma Program (CAP) at Hasbro Children's Hospital, the CDC, and the Pediatric Practice Enhancement Project (PPEP). The OFRCSHCN is in the process of placing a parent consultant in the Pediatric Intensive Care Unit (PICU) of the state's only children's hospital (Hasbro).

Healthy Child Care Rhode Island Initiative (HCCRI) continues to work with a variety of partners to provide training, TA, and information to childcare providers to help them to better accommodate CSHCN in childcare. The DFH will continue to include parents with CSHCN on the HCCRI Advisory Board to assure that this issue remains a priority.

The DFH's Data & Evaluation Unit worked collaboratively with the DFH's Communications Unit and the DFH's OFRCSHCN to publish findings from the 2001 National Survey of CSHCN. The publication includes data on family satisfaction with services received, access to "medical homes", and impact of caring for a CSHCN, and was disseminated during a conference on "medical homes" with 150 attendees held in March of 2005 sponsored by the Office of CSHCN, the Rhode Island Parent Information Network (RIPIN), and Family Voices Rhode Island //2006//.

c. Plan for the Coming Year

/2005/ The DFH will continue to work to increase the number of families with CSHCN who partner in decision-making and are satisfied with the services they receive /2005//.

/2006/ Since it distributed the Complete Care Notebooks in FY2005, the DFH's OFRCSHCN has received a significant number of inquiries and distribution requests from community providers, advocacy, and family support agencies for more copies //2006//.

/2005/The OFRCSHCN will continue to support the activities of the SSI Team //2005//. ***/2006/ In FY2004 and 2005, members of the SSI team visited each SSA Office in RI to train staff on local resources and deliver Family Voices Resources Guides.***

The DFH will continue to support the Child Development Center (CDC). In FY2006, the CDC will find a new home. Hasbro Children's Hospital will open the Center for Special Children, which will house the CDC, Rhode Island Hospital's Pediatric Outpatient Clinics, (such as neurology, urology, psychology, etc.), CEDARR and Early Intervention. The DFH and the two parent consultants assigned to the CDC will have a role in planning and transitioning the center.

The OFRCSHCN will continue to place parent consultants including in the Community Asthma Program (CAP) at Hasbro Children's Hospital, the CDC, and the Pediatric Practice Enhancement Project (PPEP).

The DFH's Healthy Child Care Rhode Island Initiative (HCCRI) will also work with the Rhode Island Department of Human Services' (RIDHS's) Therapeutic and Youth Care Program, which places additional staff members in child care centers who care for CSHCN. The HCCRI Project Director also works with the RIDHS to expand their program to allow CSHCN to attend childcare in natural settings through placing additional staff in classrooms //2006//. /2005/ HCCRI will continue to include parents with CSHCN on the HCCRI Advisory Board to assure that the identification of resources for this population remains a priority //2005//.

/2006/ The DFH's Data & Evaluation Unit, in collaboration with the DFH's OFRCSHCN, will analyze data from the National Survey of Children's Health, which also contains questions on CSHCN and parent satisfaction. In addition, the DFH's Birth Defects Program will survey families of children with birth defects to determine satisfaction with services and the system of care//2006//.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				53.9	53.9
Annual Indicator			53.9	53.9	53.9

Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	53.9	55.2	55.2	55.2	55.2

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

2003: SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

/2006/ The DFH continued to work to increase the number of CSHCN in RI who have a "medical home". The DFH collaborated with key state and community partners to implement the PPEP, which places trained parent consultants into eight pediatric primary care practices statewide.

In 2004, the DFH's Complete Care Notebook was in the development process. The notebook, which was the idea of parents, is a portable organizer to record CSHCN's important health information, from birth through adulthood.

The DFH, along with key state and community partners, sponsored a "medical home" conference with national speakers. The conference offered sessions on the components of a "medical home", a special track for physicians on financing a "medical home", RI's care coordination system, and local and national resources.

The DFH worked with RIEMA and Emergency 911 worked to develop an accurate and functional registry of people with disabilities for emergency planning and response. Individuals with disabilities and parents of CSHCN were involved in all phases of development through formative research and participation on workgroups.

RLP continued to work on implementing activities related to expanding the capacity and cultural competency of early childhood learning programs in the city. Newport County CATCH provided "medical home" training and care coordination support. Mt Hope CATCH completed a comprehensive assessment of "medical homes" and began developing a strategic plan to improve the local system of services. Washington County CATCH developed strategies to improve the local system of mental health services for children.

The DFH's Successful Start initiative engaged in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system, one of which focuses on "medical homes". Ongoing family input and cultural competency represented important components of this initiative //2006//.

/2005/ The DFH continued its contract with NERGG to provide technical assistance and administrative support for genetics related activities and to facilitate the ongoing implementation of the state genetics plan //2005//. ***//2006// A 5th annual genetics conference was held in FY2004. HEALTH assisted the RIPHA's efforts to disseminate a culturally and linguistically appropriate genetics brochure targeted at low-literacy populations. HEALTH's Genetics Screening Advisory Committee completed a survey of all HEALTH programs involvement with genetics.***

The DFH's Data & Evaluation Unit analyzed data from the National Survey of CSHCN, which includes data on coordination and comprehensiveness of care. In addition, the DFH's "Medical Homes" work group developed measures of coordinated and comprehensive care //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Works with other state agencies who contract for services for CSHCN to incorporate "medical home" core values in contract language.		X		
2. Completed and distributed a Complete Care Notebook for families with CSHCN, at the request of families with CSHCN.		X		
3. Is working on a new statewide emergency registry form for individuals with disabilities, including CSHCN.				X
4. Contnues to administer the PPEP, which will continue to collect information regarding "medical home" core components and provide training on financing a "medical home".				X
5. Continues to enroll all pediatric providers in the state in KIDSNET to ensure that all children, including CSHCN, have a"medical home" and are linked to appropriate support services.				X
6. Continues to utilize KIDSNET to refer children identified to be risk positive or risk suspect through the Level I screening process to the FOP.				X
7. Has made a web-based version of KIDNET accessible to pediatric providers, school nurse teachers, Head Starts, audiologists, and 27 school districts.				X
8. Supports Ready to Learn Providence (RLP) and 3 RIAAP CATCH systems development investments which work to build "medical home" capacity in participating communities.				X
9. Participates on the CEDARR Interdepartmental Team with the RI Departments of Human Services (RIDHS), Children, Youth, and Families (RIDCYF), and Education (RIDE).				X
10. Completed a statewide strategic plan as a part of the Successful Start systems development intiative.				X

b. Current Activities

/2006/ The DFH continues to work to ensure that CSHCN ages 0-18 receive coordinated, ongoing, comprehensive care within a "medical home". The DFH OFRCSHCN works with other state agencies who contract for direct services to families raising CSHCN to incorporate "medical home" core values in contract language. A CEDARR Interdepartmental Team is made up of the RIDHS, the DFH, the RIDE, and the RIDCYF. The team is responsible for program monitoring and oversight, policy review and

revision, and program development.

The DFH's Complete Care Notebook was printed and distributed throughout the state. The notebooks are provided to families through parent consultants. The notebooks have been exceptionally well received by community programs and families. The DFH is working on the last edits for the new emergency registry form. The forms are being tested by people with disabilities and family members as well as by emergency personnel. Once final approval of the form happens, the DFH will begin a statewide distribution plan and marketing effort.

The DFH will continue to implement the PPEP, which will continue to collect information regarding "medical home" core components, provide specialized training on financing a "medical home", and expand to several more sites as resources allow. DFH-supported parent consultants have been placed in the Child Development Center (CDC), the Community Asthma Program (CAP), the NICU at Women & Infants Hospital, and the Pediatric Practice Enhancement Project (PPEP).

The DFH continues to work to enroll all pediatric providers in the state in KIDSNET to ensure that all children, including CSHCN, are identified and are linked to a "medical home" and appropriate support services. KIDSNET triggers Level I information results in referrals to the FOP for risk positive or risk suspect children. A web-based application implemented in FY2004 facilitates KIDSNET's capacity for more rapid expansion to additional primary care providers, school nurse teachers, Head Starts, and audiologists. In FY2005, KIDSNET was made accessible to 27 of the state's school districts and continuous efforts are being made to enroll other school districts.

HEALTH's Genetics Advisory Committee continues to meet and advise the Director of Health on topics related to genetics during FY2005. RLP, Newport County CATCH, Mt. Hope CATCH, and Washington County CATCH investments continued to improve local infrastructures that support "medical homes" for children (including CSHCN). Successful Start's 2-year planning process resulted in a strategic plan, which will be implemented in FY2006.

The DFH's Data & Evaluation Unit published findings from the 2001 National Survey of CSHCN, which was disseminated during a "medical homes" conference //2006//.

c. Plan for the Coming Year

/2006/ The DFH will continue to work to increase the number of CSHCN in RI who have a "medical home". The DFH will continue to participate on the CEDARR Interdepartmental Team, which is responsible for program monitoring and over-sight, policy review and revision, and program development.

Since it distributed the Complete Care Notebooks in FY2005, the DFH has received a significant number of inquiries and distribution requests from community providers, advocacy, and family support agencies for more copies. The DFH will continue to administer the PPEP. The PPEP will collect more information regarding "medical home" core components, provide specialized training on financing a "medical home", and expand to several more sites as resources allow. The DFH will update and further disseminate the chart book that that describes data from the National Survey of CSHCN, which includes data on coordination and comprehensiveness of care //2006//.

/2005/ The DFH will continue to work to enroll all pediatric providers in the state in KIDSNET to ensure that all children, including CSHCN, are identified and are linked to a "medical home" and appropriate support services //2005//. ***/2006/ All Head Start agencies are now***

connected to KIDSNET and using it to verify immunization and lead screening. During FY2006, Head Start agencies will also be able to verify newborn blood spot and hearing screening through KIDSNET.

In FY2004, a DFH work group developed selected performance indicators of "medical homes". The Data & Evaluation Unit will begin to utilize the measures developed by the DFH's Medical Home workgroup to determine the percentage of Rhode Island children who have a "medical home" //2006//.

/2005/ The DFH's FOP will continue to link children, including CSHCN, from birth to six years old, to a "medical home". FOP home visitors will continue to provide culturally appropriate family support, outreach, referral, education, and assistance with linkages to health insurance and other health care needs //2005//.

/2006/ The DFH will continue to support "medical home" community needs assessment and systems development in culturally diverse urban communities through RLP, Newport County CATCH, Mt. Hope CATCH, and Washington County CATCH. Successful Start will implement its statewide strategic plan in FY2006 and will continue to include ongoing family input.

The DFH will continue to distribute emergency forms and market the emergency registry. The OFRCSHCN will also work with RIEMA and E-911 to assure that the registry is operating effectively and that data collected in registry is accessible to and utilized by emergency personnel.

The DFH will continue to support parent consultants at the Child Development Center (CDC) and the Community Asthma Program (CAP) at Hasbro Children's Hospital //2006//.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				68.9	68.9
Annual Indicator			68.9	68.9	68.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	68.9	70.2	70.2	70.2	70.2

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

2003: SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

/2005/ The DFH continued to work to increase the percentage of CSHCN, ages 0-18, whose families have adequate private and/or public insurance to pay for the services they need. The DFH's Family Resource Counselor Program (FRC) continued to screen and enroll eligible families into Medicaid (including RIte Care or RIte Share) and other health financing programs (including SSI and Katie Beckett) //2005//. ***/2006/ During FY2004, culturally diverse FRCs were located in 20 community health center sites and 4 hospital-based clinics throughout the state //2006//***. /2005/As the Rhode Island Department of Human Services (RIDHS) transitioned CSHCN from fee-for-service Medicaid to Medicaid managed care on a voluntary basis, the DFH worked with the RIDHS, the RI Health Center Association, and Covering Kids RI to train FRCs to support the particular needs of this population during the transition //2005//.

/2006/The OFRCSHCN's Pediatric Practice Enhancement Project (PPEP) assisted over 300 families with CSHCN in 2004 on issues concerning insurance, education, and access to mental health services. Almost 25% of these families required direct assistance in accessing insurance //2006//.

/2005/ The DFH's Family Outreach Program (FOP) continued to identify families with no or inadequate health insurance and refer them to appropriate health funding programs, including Medicaid, SSI, and Katie Beckett. Culturally diverse FOP home visitors continued to help families complete applications as needed. The DFH's Communication Unit continued to support the toll-free Family Health Information Line, which continued to refer families to appropriate resources, including financial assistance. The Family Health Information Line, which is a statewide resource for all families, including those with CSHCN, and is staffed by bi-lingual information specialists. Culturally appropriate informational materials for families were distributed through the Communication Unit's centralized Distribution Center //2005//.

/2006/ During FY2004, the DFH's Data & Evaluation Unit continued to analyze data from the National Survey of CSHCN, including those related to adequacy of health insurance. A special analysis was conducted that focused on the impact of caring for CSHCN on families specific to financial and employment issues. Families with no insurance at some point during the past year were three times more likely to experience financial and employment problems in caring for their child than parents who were insured for the entire year //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Continues to support the Pediatric Practice Enhancement Project (PPEP), which includes a strong service coordination component and which links families with CSHCN to Medicaid, SSI, and Katie Beckett.				X
2. Continues to participate on the RI Department of Human Services' (RIDHS's) CEDARR Interdepartmental Team.				X
3. Completed and distributed a Complete Care Notebook for families with CSHCN, at the request of families with CSHCN.		X		
4. Supports culturally diverse Family Resource Counselors (FRCS) in 20 community health center sites and 4 hospitals to identify and enroll families with CSHCN onto Medicaid, SSI, and Katie Beckett.				X
5. Continues to support culturally diverse Family Outreach Program (FOP) home visitors, which refer families with CSHCN to Medicaid, SSI, and Katie Beckett.				X
6. Continues to produce and disemminate a data book that includes data on individuals with disabilities (including CSHCN) and CSHCN transitioning to adulthood.			X	
7. Presented an analysis of the National Survey of CSHCN data at the 2004 MCH Epidemiology Conference.			X	
8. Submitted an article to the MCH Journal on the impact of caring for CSHCN on families in Rhode Island, which was accepted for publication.			X	
9.				
10.				

b. Current Activities

/2005/ The DFH continues to work to increase the percentage of CSHCN, ages 0-18, whose families have adequate private and/or public insurance to pay for the services they need //2005//. ***/2006/ The DFH's PPEP contains a strong service coordination component, which ensures that the families of CSHCN receiving services through participating primary care sites are linked to financial resources for which they may be eligible (i.e. SSI, Medicaid, Katie Beckett, etc.). Through this project, the DFH is supporting pediatric practices with high concentrations of CSHCN through placement of trained parent consultants in the offices to assist families with systems navigation and accessing health insurance //2006//***.

/2005/ The DFH continues to actively participate in the implementation of CEDARR. The DFH is a part of the CEDARR Interdepartmental Team, along with RIDHS, the RIDE, and the RIDCYF. The Team is responsible for program monitoring and oversight, policy review and revision, and program development. CEDARR includes a strong care coordination component, which includes the coordination of financial resources for which families with CSHCN may be eligible (i.e. SSI, Medicaid, Katie Beckett, etc.) //2005//.

/2006/ The DFH developed a Complete Care Notebook for health care providers to give to families with CSHCN. The notebook includes a list of services and resources in Rhode Island, worksheets for parents to track information about health care appointments and the child's conditions, sheets for recording emergency information, and tips for building partnerships with health care providers. The notebook was distributed to families with CSHCN through the CDC, EI, the state's only NICU, and primary care settings //2006//.

/2005/ The DFH's Family Resource Counselor (FRC) Program continues to screen and enroll eligible families into Medicaid (including RIte Care or RIte Share) and other health financing programs (including SSI and Katie Beckett) //2005//. ***/2006/ Culturally diverse FRCS are located in 20 community health center sites and 4 hospital-based clinics throughout the***

state //2006//.

/2005/ The DFH's Family Outreach Program (FOP) refers families with no or inadequate health insurance to appropriate funding programs. FOP home visitors help families complete applications as needed. The DFH supports the toll-free Family Health Information Line, which refers families to appropriate resources, including financial assistance //2005//.

/2006/The DFH developed a chart book that describes findings from the 2001 National Survey of CSHCN and includes data regarding adequacy of health insurance. The DFH also presented an analysis of the National Survey of CSHCN data during the 2004 MCH Epidemiology Conference. The study showed the relationship between lack of insurance and financial and employment problems. Further analysis was conducted and an article has been accepted for publication in the MCH Journal//2006//.

c. Plan for the Coming Year

/2005/ The DFH will continue to work to increase the percentage of CSHCN, ages 0-18, whose families have adequate private and/or public insurance to pay for the services they need. The RIDHS is in the process of transferring CSHCN from traditional fee-for-service Medicaid to RIte Care on a voluntary basis. The DFH's OFRCSHCN will continue to partner with Family Voices and other partners to advocate for more coverage for CSHCN with private insurance //2005//. ***/2006/ The DFH's PPEP will continue to ensure that families with CSHCN, from birth to twenty-one years of age, are linked to adequate health financing programs, including Medicaid, SSI, and Katie Beckett.***

The DFH will continue to participate on the CEDARR Interdepartmental Team during FY2006 //2006//. /2005/ The Team will continue to be responsible for program monitoring and over-sight, policy review and revision, and program development. CEDARR includes a strong care coordination component, which ensures that families with CSHCN are linked to financial resources for which they may be eligible //2005//

/2006/ The DFH will outreach to families on the use of the Complete Care Notebook to track expenses and determine adequacy of insurance. The notebook includes a list of services and resources in Rhode Island, worksheets for parents to track information about health care appointments and the child's conditions, sheets for recording emergency information, and tips for building partnerships with health care providers. The notebook was distributed to families with CSHCN through the Child Development center (CDC), Early Intervention Programs, the state's only NICU, primary care settings, and through care coordination centers //2006//.

/2005/ The DFH's FRC Program will continue to screen and enroll eligible families into Medicaid (including RIte Care or RIte Share) and other health financing programs (including SSI and Katie Beckett) //2005//. ***/2006/ Culturally diverse FRCS are located in 20 community health center sites and 4 hospital-based clinics throughout the state //2006//***. /2005/ The DFH's Communication Unit will continue to support the toll-free Family Health Information Line, which will continue to refer families to appropriate resources, including financial assistance. Culturally appropriate informational materials will continue to be distributed through the Communication Unit's centralized Distribution Center //2005//.

/2006/ The DFH's Data & Evaluation Unit will analyze data from the National Survey of Children's Health, which includes data on CSHCN and insurance //2006//.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				78.8	78.8
Annual Indicator			78.8	78.8	78.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.8	80	80	80	80

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

2003: SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

/2005/ The DFH continued to work to ensure that families with CSHCN ages 0-18 report that services are organized so that they can use them easily //2005//. ***/2006/ The DFH's state early childhood comprehensive systems development initiative, Successful Start, engaged in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system. The 5 components were: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including CSHCN. Ongoing family input and cultural competency represented important components of this initiative.***

The DFH's OFRCSHCN participated in the implementation on ongoing quality assurance activities of CEDARR. The CEDARR Interdepartmental Team is made up of the Rhode Island Department of Human Services (RIDHS), the DFH's OFRCSHCN, the Rhode Island Department of Education (RIDE), and the Rhode Island Department of Children, Youth and Families (RIDCYF). The Team is responsible for program monitoring and oversight, policy review and revision, and program development. Family and program input is provided through the CEDARR Policy Advisory Committee and the CEDARR Quality

Panel to Facilitate quality Improvement.

In 2004, the DFH's Complete Care Notebook was in the development process through the OFRCSHCN. The Complete Care Notebook was developed in response to requests from families of CSHCN for a portable organizer to record and file their child's important health information, from birth through adulthood. One of the main stressors for families is the need to have detailed heath care information readily available for the numerous professionals and service providers involved in their child's care. Having a notebook to categorically record and organize their child's emergency information, health history, health tracking, daily routine, care providers etc. is a significant tool to assist families. The Care Notebook also provides families with a community and state resource guide.

The DFH's Pediatric Practice Enhancement Project (PPEP) parent consultants participated in several quality assurance meetings with the CEDARR Interdepartmental Team and the CEDARR Family Service agencies in order to enhance collaboration, reduce duplication and clarify roles. These meetings led to policy changes in the CEDARR Program regarding access and service provision.

The DFH's Data & Evaluation Unit analyzed data from the National Survey of CSHCN including family perceptions of community-based service systems//2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supports family and program input through the CEDARR Policy Advisory Council, the CEDARR Quality Panel, and the Pediatric Practice Enhancement Project (PPEP).				X
2. Completed and distributed a Complete Care Notebook for families with CSHCN, at the request of families with CSHCN.		X		
3. Completed a statewide strategic plan as a part of the Successful Start systems development intiative.				X
4. Submitted an article to the MCH Journal on the impact of caring for CSHCN on families in Rhode Island, which was accepted for publication.			X	
5. Supports parent consultants at the Child Development Center (CDC), which provides comprehensive medical services to medically complex CSHCN.				X
6. Supports parent consultants at the hospital-based Community Asthma Program (CAP) and the community-based Pediatric Practice Enhancement Project (PPEP).				X
7. Is in the process of placing a parent consultant at the pediatric intensive care unit (PICU) at Hasbro Children's Hospital.				X
8. Supports a parent consultant in the Woman & Infants Hospital Newborn Intensive Care Unit (NICU).				X
9.				
10.				

b. Current Activities

/2005/ The DFH continues to work to ensure that families with CSHCN ages 0-18 report that

services are organized so that they can use them easily //2005//. ***/2006/ The DFH's OFRCSHCN continues to actively participate in the implementation and continuous quality improvement of CEDARR. Family and program input is provided through the CEDARR Policy Advisory Committee, the CEDARR Quality Panel, and the DFH's Pediatric Practice Enhancement Project (PPEP) to facilitate quality improvement.***

In FY2005, the OFRCSHCN's Complete Care Notebook was printed and distributed to community programs that service large populations of CSHCN, such as the Child Development Center at Rhode Island Hospital, Early Intervention, CEDARR Family Centers, and pediatric practices participating in the DFH's " Medical Home" initiative entitled the Pediatric Practice Enhancement Project (PPEP). The Complete Care Notebooks are provided to families through parent consultants located in these community programs to provide support and assistance to families. The Parent Consultants were provided with training on the utilization of the Complete Care Notebooks through the OFRCSHCN. The initial printing of 1,000 copies of the Complete Care Notebooks impacted program distribution selection and allocation. The Complete Care Notebooks have been exceptionally well received by community programs and families as perceived as a long over-due necessary tool to assist and support families raising CSHCNs //2006//.

The DFH's state early childhood comprehensive systems development initiative, Successful Start, engaged in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system. The 5 components are: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including CSHCN. This planning process resulted in a strategic plan to create positive systemic statewide change around the five components. In FY2006, Successful Start will implement the strategic plan. Ongoing family input and cultural competency represent important components of Successful Start.

The DFH supports parent consultants in the Child Development Center (CDC), the Pediatric Practice Enhancement Project (PPEP), the Community Asthma Program (CAP), and the NICU at Women & Infants Hospital. It is planning to support a parent consultant in the state's only PICU as well.

The DFH's Data & Evaluation Unit submitted an article to the MCH Journal on the impact of caring for CSHCN on families in Rhode Island. The article, which was accepted for publication, included data on family perception of community-based systems ***//2006//.***

c. Plan for the Coming Year

/2005/ The DFH will continue to work to ensure that families with CSHCN ages 0-18 report that services are organized so that they can use them easily. The OFRCSHCN will continue to actively participate in the implementation of CEDARR. The CEDARR Interdepartmental Team is made up of the RIDHS, HEALTH's OFRCSHCN, the RIDE, and the RIDCYF. The Interdepartmental Team is responsible for program monitoring and oversight, policy review and revision, and program development //2005//. ***/2006/ Family and program input will be provided through the CEDARR Policy Advisory Committee, the CEDARR Quality Panel, and the DFH's Pediatric Practice Enhancement Project (PPEP) to facilitate quality improvement.***

Since it distributed the Complete Care Notebooks in FY2005, the DFH's OFRCSHCN has received a significant number of inquiries and distribution requests from community providers, advocacy, and family support agencies for more copies. For FY2006, funding has not yet been identified for on-going distribution of the Care Notebooks to allow for re-supply to the original program recipients or the many others interested entities.

The OFRCSHC will collaborate with the RIDHS, NHPRI, Family Voices Rhode Island and RIPIN to expand and fund the DFH's PPEP, which was developed to alleviate some of the administrative burden faced by pediatricians and to support pediatric practices in providing comprehensive and coordinated care to CSHCN within a "medical home". The PPEP places trained parent consultants into eight pediatric primary care practices statewide. The primary role of the parent consultant is to create linkages between families with CSHCN and the pediatric practice and the community as a whole.

The DFH will increase the number of families with CSHCN who have access to easy-to-use community based services systems through extensive collaboration with other sate agencies, specifically RIDHS, RIDCYF, and RIDE. It is expected that EI (now housed in the RIDH S) will work with KIDSNET to ensure continuation of a data exchange mechanism and develop measures to assure the quality of the data and to assess quality of services.

The DFH's state early childhood comprehensive systems development initiative, Successful Start, engaged in a two-year planning process to assess capacity, quality, and integration issues surrounding five core components of the state's early childhood system //2006//. /2005/ The 5 components are: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including CSHCN //2005//. ***/2006/ This planning process resulted in a strategic plan to create positive systemic statewide change around the five components. In FY2006, Successful Start will implement the strategic plan. Ongoing family input and cultural competency will continue to represent an important part of this initiative as the plan is implemented //2006//***.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				5.8	5.8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	6.4	6.4	6.4	6.4

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

2003: SLAITS-Rhode Island data for 2002 are provided. SLAITS Survey is conducted every 5 years.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

/2005/ The DFH's OFRCSHN worked closely with the RIDHS to help implement CEDARR and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care on a voluntary basis //2005//.

/2006/ In FY2004, the DFH's Complete Care Notebook was in the development stage. The notebook was developed in response to requests from families of CSHCN for a portable organizer to record and file their child's important health information, from birth through adulthood. The notebook also provides families with a community and state resource guide //2006//.

/2005/ The DFH was a key partner in the implementation of the Ticket to Work Self-Sufficiency Program, which is a new statewide Social Security imitative that will impact individual's ages 18-21 years with disabilities or blindness. The initiative offers support services for transition to independence through no cost employment services previously limited to the RIDHS's Office of Rehabilitative Services //2005//.

/2006/ The DFH participated in the Rhodes To Independence, Youth in Transition Workshop, which is funded through a Medicaid infrastructure Grant (MIG) and which focuses on eliminating barriers to employment for all people with disabilities. The committee's accomplishments include a white paper highlighting the gaps faced by youth with disabilities transitioning to adult care, a "Train the Trainer" manual that serves as a resource for students, families, and professionals that provides information on options for higher education and employment, and developed a fact sheet highlighting the Social Security work incentives //2006//.

/2005/ The DFH continued to participate on the RI Transition Council, which was created by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life. The Council continued to monitor the RI Transition Academy, promote transition activities such as the Youth Leadership Forum, and review current agency transition policies and practices. The Council also reviewed intra-agency agreements for state member agencies and develop new goals and objectives through a strategic planning process.

The DFH continued to produce and disseminate an annual "Disability Data Book" to provide a basis for developing effective needs assessments & interventions for individuals with disabilities, including CSHCN who are transitioning to adulthood //2005/. ***/2006/ The DFH hosted a disability data forum to disseminate the book in addition to other strategies.***

In collaboration with the RIAAP, the DFH administered a survey to all practicing primary care pediatricians in the state to document current health care transition practice of all adolescents with a specific emphasis on those with special health care needs. The DFH also began to work with the adult and pediatric rehabilitation units at RI Hospital to facilitate a seamless transition to adult rehabilitative care //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Is working closely with the RI Department of Human Servcies (RIDHS) on the implementaion of CEDARR.				X
2. Is working closely with the RIDHS as the RIDHS transitions CSHCN from a Medicaid fee-for-service system to a Medicaid managed care system on a voluntary basis.				X
3. Completed and distributed a Complete Care Notebook for families with CSHCN, at the request of families with CSHCN.		X		
4. Continues to participate on the "Rhodes To Independence" Youth In Transition Committee.				X
5. Continues to participate on the Rhode Island Transition Council.				X
6. Continues to produce and disemminate a data book that includes data on individuals with disabilities (including CSHCN) and CSHCN transitioning to adulthood.			X	
7. Developed and will implement a survey of practicing primary care pediatricians to better understand the transition process for CSHCN transitioning to adult health care systems.			X	
8. Continues to work with the adult and pediatric rehabilitation units at RI Hospital to facillitate a seamless transition to adult rehabiliative care.				X
9. Continues to support a 3 year evalaution study of students who have graduated from high school to determine the effectiveness of transition services.			X	
10. Continues to support the Child Development Center (CDC) and the PPEP, both of which serve CSHCN transitioning to adult health care systems.				X

b. Current Activities

/2005/ The DFH continues to work to increase the percentage of CSHCN, ages 0- 18, who have received the services necessary to transition to adult health care, work, and independence. The DFH's OFRCSHN continues to work closely with RIDHS to help implement CEDARR and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care on a voluntary basis //2005//.

/2006/ In FY2005, the Complete Care Notebook was printed and distributed to community programs that service large populations of CSHCN throughout the state. The notebooks are provided to families through parent consultants located in these community programs to provide support and assistance to families. The Complete Care Notebooks have been exceptionally well received by community programs and families.

The DFH continues to participate on the Rhodes To Independence, Youth in Transition Committee. The Committee is working on two main projects for the year: development of a "Youth Interview Tool" that provides youth with all necessary information during the process of obtaining employment and strategic planning to assure that all youth have access to appropriate assistive technology to maximize employment and higher

education outcomes.

The DFH continues to participate on the RI Transition Council. The DFH continues to produce and disseminate an annual "Disability Data Book" on individuals with disabilities, including CSHCN who are transitioning to adulthood. The DFH will host a disability data forum to disseminate the book along with other strategies.

/2006/ The OFRCSHCN, in collaboration with the RIAAP, has developed and will administer a survey to all licensed practicing primary care pediatricians in Rhode Island in order to further understand the health care transition process from the perspective of primary care physicians serving adults. The findings of the survey will be used to develop outreach, training, and education strategies for youth, families, and health care professionals.

The DFH will continue to work with the adult and pediatric rehabilitation units at RI Hospital to facilitate a seamless transition to adult rehabilitative care. The DFH sponsored an interactive session at the Medical Home Partnership meeting in which national and local transition specialists brought awareness to the issues concerning transition.

In collaboration with RIDE, the DFH will continue to support a 3-year evaluation study of students who have graduated from high school to determine the effectiveness of CSHCN services. The DFH continues to support the CDC, which provides services to medically complex CSHCN and the Pediatric Practice Enhancement Project (PPEP). Both serve CSHCN who are transitioning to adulthood //2006//.

c. Plan for the Coming Year

/2005/ The DFH will continue to work to increase the percentage of CSHCN, ages 0- 18, who have received the services necessary to transition to adult health care, work, and independence. The OFRCSHCN will work to ensure that all CSHCN are healthy and ready to work in two ways: 1) through transitioning from child to adult health care systems and 2) through transitioning to secondary education and employment //2005//.

/2006/ Since it distributed the Complete Care Notebooks in FY2005, the DFH's OFRCSHCN has received a significant number of inquiries and distribution requests from community providers, advocacy, and family support agencies for more copies.

In collaboration with the RIAAP, the DFH surveyed all licensed, practicing primary care pediatricians in the state to establish a baseline of current practices in the transition and transfer of adolescent CSHCN and to identify barriers that prevent a seamless transition to adult care. Since the needs assessment is complete and a baseline of current practices has been identified, the plan is to foster collaboration among pediatricians, family practice physicians, ands other primary care physicians to address the issue.

The DFH will continue to participate on the "Rhodes To Independence" Youth and Transition Committee. Activities will include the following: completion of the "Youth Interview Tool" and the Assistive Technology strategic plan. The Steering Committee will identify additional objectives as a part of its annual planning process.

The DFH will continue to participate on the RI Transition Council. In FY2006, the Council will continue to monitor the RI Transition Academy, promote transition activities such as the Youth Leadership Forum, and review current agency transition policies and practices. The Council will also continue to review intra-agency agreements for state

member agencies and implement new goals and objectives that were developed through a comprehensive strategic planning process.

The DFH will continue to produce and disseminate an annual "Disability Data Book" to provide a basis for developing effective needs assessments and interventions for individuals with disabilities, including CSHCN who are transitioning to adulthood. The first version of the Data Book was produced in FY2000. The DFH will host a disability data forum to disseminate the book in FY2006. In addition, the DFH will continue to disseminate the book to community-based agencies and policy-makers throughout the state //2006//.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	81	81.4	81.9	85.5	87.7
Annual Indicator	80.5	81.7	84.5	85.2	88.0
Numerator	10141	10101	10561	10829	11280
Denominator	12598	12364	12498	12710	12818
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.5	86.5	86.5	87	87

Notes - 2002

The results of the July '99-June '00 National Immunization Survey showed that the estimated vaccination coverage with the 4:3:1:3 series among Rhode Island children aged 19-35 months dropped by 7 percentage points from the previous year. Survey results also indicated that many other states had a similar drop. Upon reviewing the socio-demographic characteristics of the sample, more samples were drawn from the high risk population in FY2000 [21.1% were below poverty] compared to FY1999 [13.4% were below poverty].

The results of Clinic Assessments for children aged 19-35 months conducted by the RI Immunization Program in 2000 indicate that there is no significant change in the 4:3:1:3 series coverage among these children compared to those of 1999.

2001: For 1996-1999, the Rhode Island Department of Health reported the 4:3:1:3 immunization series only. This was done to correlate with Rhode Island school regulations for immunization. The regulations changed in 2000 mandating that by school entry children have completed the 4:3:1:3:3 immunization series. Data for this performance measure now reflect

the 4:3:1:3:3 series and the targets for 2000-2005 have been lowered to reflect these changes.

2002: Numerator and Denominator for data prior to 1998 reflect children under the age of three.

Notes - 2003

2003: Starting with 2000, data for this performance measure reflects the 4:3:1:3:3 series collected through the National Immunization Survey. The data for 2003 are provisional and will be updated when data are final.

Notes - 2004

2004: Starting with 2000, data for this performance measure reflects the 4:3:1:3:3 series collected through the National Immunization Survey. The data for 2004 are provisional and will be updated when data are final.

a. Last Year's Accomplishments

/2006/The DFH provide all recommended vaccines for all children in the state (There is no differentiation or tiered system. Rhode Island is a universal state). Influenza vaccine was available (as supply allowed) for all children ages 6 months through 1 year. Due to a national influenza vaccine shortage, FluMist was offered to healthy children ages 5 years through 18 years.

The DFH wrote an article about the importance of childhood immunization for the Rhode Island Family Guide. The article included the current recommended immunization schedules and addressed common questions that parents have about childhood immunization. The article also referred readers to the DFH's Family Health Information Line to request a Health and Safety Record for their child(ren).

The DFH developed a new culturally and linguistically appropriate immunization brochure to supplement existing vaccine-specific brochures. In addition, the DFH redesigned the Immunization Program website to include sections for families, healthcare providers, childcare professionals, and school professionals.

The DFH (with input of members of the statewide Childhood Immunization Action Coalition) developed a resource binder for health care providers. The binder includes a variety of reference documents for health care providers as well as samples of educational materials that can be distributed to families. The educational materials can be ordered in bulk at no charge.

The DFH hosted a conference for childcare directors/nurses, school nurse teachers, and Head Start health coordinators to provide up-to-date information on health topics (including immunizations).

The DFH, in collaboration with the Ocean State Adult Immunization Coalition, sponsored the second annual Immunizations Across the Lifespan event at the Warwick Mall to raise awareness about the importance of immunizations for all ages. Families with young children were referred to primary care providers or free immunization clinics. The event was promoted through press releases to the media.

The DFH continues to use KIDSNET to capture maternal Hepatitis B information. Infants with Hepatitis B positive mothers were referred to the DFH's Family Outreach Program (FOP) for case management services to ensure completion of Hepatitis B vaccination series //2006//

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Provides all recommended vaccines for all children in Rhode Island, including influenza vaccine during influenza season, for all children ages 6 months through 18 years.				X
2. Provides free immunizations to uninsured and newly arrived immigrant children.	X			
3. Submitted an article on the importance of immunizations in the Rhode Island Family Guide.			X	
4. Continues to revise and distribute culturally and linguistically appropriate immunization brochures to families throughout the state.			X	
5. Continues to update the RI Department of Health's Immunization web site to include specific sections for health care pofessionals, child care providers, school personnel, and culturally diverse families.			X	
6. Distributed an immunization resource manaual and a "best practice" instructional video to health care providers, which includes culturally and linguistically appropriate educational materials for families.		X		
7. Hosted an annual conference for school nurse teachers, Head Start personnel, and child care directors to provide up-to-date information on a variety of health care issues, including immunizations.		X		
8. Hosted an annual immunization awareness event at the Warwick Mall.			X	
9. Implemented a pilot project to assess the immunization status of children in about 1,200 home child care settings.			X	
10. Utilizes KIDSNET to track the immunization status of all children born after 1/1/97.				X

b. Current Activities

/2006/ The DFH continues to provide all recommended vaccines for all children in the state, including influenza vaccine during influenza season to all children ages 6 months through 18 years. The DFH began a pilot project to determine the immunization status of children receiving childcare through approximately 1,200 childcare providers. In addition, the DFH is working with the state Refugee Program to ensure vaccination of refugee children new to RI.

The DFH submitted an article in the Rhode Island Family Guide. The article included the current recommended immunization schedules and addressed common questions parents have about immunizations. The DFH continues to revise and distribute culturally and linguistically appropriate immunizations brochures, including vaccine-specific brochures. The DFH continues to update the immunization website to include specific sections for families, health care providers, childcare professionals, and school professionals.

The DFH distributed an immunization resource manual and a "best practice" instructional video (Immunization Techniques) to health care provider practices and clinic where childhood immunizations are routinely administered. The manual includes educational materials for them to use with the families they serve.

The DFH hosted and annual conference for childcare directors/nurses, school nurse teachers, and Head Start health coordinators to provide up-to-date information on health issues (including immunizations). The DFH continues to host an annual immunization awareness event at the Warwick Mall. WIC assesses the immunization status of children

receiving WIC services. Children who are behind on their immunizations are referred to their primary care provider or to one of the free immunization clinics //2006//.

/2005/KIDSNET sends families of all newborns a congratulations card, which includes information about the importance of timely immunizations. KIDSNET tracks immunizations for all children born after 1/1/97 and sends reports to on-line primary care providers regarding their patients' immunization status. All Head Start agencies are now connected to KIDSNET and are using it to verify immunization screening. PCPs can refer children who were behind on their immunizations to the DFH's FOP for follow-up. Auto-dial messages or mailed "well-child reminders" are sent to families at specified intervals//2005//. ***/2006/ An immunization algorithm was added to KIDSNET in April 2005 and is available on the Internet. The algorithm provides recommendations for when a vaccine is next due and when a series is complete. The DFH continues to uses KIDSNET to capture maternal Hepatitis B information.***

The DFH's Healthy Child Care Rhode Island (HCCRI) initiative provides culturally appropriate immunization informational materials to families through the Child Care Support Network (CCSN) //2006//

c. Plan for the Coming Year

/2006/ The DFH will continue to provide all recommended vaccines to all providers, free immunizations to uninsured children, and immunization education to providers and the public to ensure that children in RI receive timely, age-appropriate immunizations. The DFH will focus its improvement rates on populations new to the country and state. In addition, the DFH will continue to offer injectable and intranasal influenza vaccine for appropriate use in children ages 6 months through 18 years. The DFH will continue its assessment of immunization rates of children receiving care through home childcare providers.

The DDH will distribute a newly designed immunization requirement manual to childcare centers, in-home daycare, Head Start agencies and schools. The manual outlines mandatory vaccination requirements and offers tools and guidelines for assessing vaccination status of children in school settings. The DFH will utilize FY2006 to create and distribute provider and patient educational materials targeting culturally diverse populations on new childhood vaccines (meningococcal conjugate and pertussis booster) and to continually evaluate and update the Immunization Program's existing website.

The Immunization Program will work with the immunization coordinator at all of the state's birthing hospitals to distribute culturally appropriate Health and Safety Records in the hospital discharge packages. The DFH will continue to host and annual educational conference for childcare directors/nurses, school nurse teachers, and Head Start health coordinators and its annual Immunize for Life event at Warwick Mall.

KIDSNET will continue to send families of all newborns congratulations cards, which will include messages about the importance of immunizations. KIDSNET will continue to track immunizations for all children born after 1/1/97 and send reports to on-line PCPs regarding their pediatric patients' immunization status. PCPs will refer children who are behind on their immunizations to the FOP. Auto-dial messages or mailed "well-child reminders" will continue to be sent to families at specified intervals. KIDSNET will continue to roll out a new web-based version of KIDSNET to provide participating providers and other authorized users (including school nurse teachers and WIC sites) with easier access to KIDSNET. All Head Start agencies will continue to use KIDSNET to

verify immunizations. KIDSNET will develop additional reporting capacity for practices to better identify children who are in need of immunizations. The immunization algorithm will also be used for QI purposes to assure that vaccines are being correctly administered.

KIDSNET will continue to be used to capture perinatal and maternal Hepatitis B information and prompt referrals for case management. WIC will continue to assess the immunization status of children receiving WIC services //2006//.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20	19.2	21.5	21.3	21
Annual Indicator	21.6	21.5	19.8	19.6	18.0
Numerator	415	424	391	386	356
Denominator	19198	19730	19730	19730	19730
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20.5	20.2	20	20	20

a. Last Year's Accomplishments

/2006/ The DFH continued its commitment to reduce teen birth rates and other risk behaviors through the following three pronged approach: 1) access to health care services, including family planning services, 2) youth development programming that focuses on preparing adults and institutions to meet the developmental needs of youth, and 3) coordinated school health programs, including quality health education and comprehensive sexuality education.

The DFH continued to support 10 Title X family planning clinics to provide confidential and low cost reproductive health services to culturally diverse teens throughout the state. The DFH's WHSRP continued to provide no cost pregnancy testing and comprehensive health risk assessment to teens in 9 Title X clinics. Teens with a negative pregnancy test were linked to family planning services and teens with a positive pregnancy test were referred to the RIDHS's Adolescent Self-Sufficiency Program for pregnant and parenting teens.

Teens with identified health risks (i.e. smoking, nutrition, substance abuse, mental health services, intimate partner violence, etc.) were referred to appropriate follow-up

services. A youth-led community-based organization (Youth In Action) provided family planning outreach, education, and referral services to racially and ethnically diverse young men, less than 20 years of age living in Providence. Young men in need of family planning services were referred to a Title X site. The state's 8 SBHCs (an additional SBHC was added in FY2004) continued to provide teenagers with access to no cost comprehensive preventive health and mental health services in racially and ethnically diverse communities. Teens in need of birth control were referred to a Title X site.

Consumers who called the DFH's Family Health Information Line were provided with "Ten Tips on Parenting teens" and referrals to the Men2B Program. The DFH and other partners launched a website for parents of 9-17 year olds and providers. The site included programs, resources, referrals, and monthly parenting tips on a variety of topics. The DFH continued support the Men2B Program. Outreach materials were used to increase Men2B enrollment in worksites, schools, and faith-based organizations. A uniform training guide was developed for Men2B trainers to build consistent messages and educational materials into the program. Through the Healthy Schools!/Healthy Kids! (HS/HK) initiative, the DFH is working to advance the development of a strong statewide infrastructure for coordinated school health programs that includes comprehensive sexuality education.

The DFH participated on an interagency work group to use data to better understand teen birth trends and outcomes. The DFH continued to track births among teens and examine trends by demographic factors. In addition, data from the YRBS and SALT have been used to look at risk behaviors, after-school activities, time left unsupervised, etc. //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provides culturally diverse adolescents with access to affordable, confidential family planning clinical and educational services through Title X family planning clinics.	X			
2. Provides culturally diverse adolescents with free, confidential pregnancy testing and comprehensive health risk assessment and referral services through the Women's Health Screening & Referral Program (WHSRP).	X			
3. Partners with the youth-led community-based organization YIA to provide family planning outreach, education, and referrals services to culturally diverse young men living in Providence.	X			
4. Supports 9 School-Based Health Centers (SBHCs) to provide culturally diverse adolescents with comprehenive preventive health services.	X			
5. Participates on a newly formed statewide Teen Pregancy Prevention Coalition.				X
6. Conducted interviews with key community partners and DFH staff to explore the feasibility of strenghtening the DFH's current level of investments in the area of maternal, or women's, health.				X
7. Engaged the services of a Stanford University student-run consulting group Youth Infusion to strenghten the DFH's capacity to involve youth in				X

the development of programs in the state.				
8. Continued to support a web site for parents of 9-17 year olds and professionals, along with other key partners.			X	
9. Continued to support the Men2B Program, which provides training and information to adult men who are parents of or who are working with middle school age boys.				X
10. Continues to administer Healthy Schools!/Healthy Kids!, which produced issues briefs around a variety of topics, including teen sexual behavior.				X

b. Current Activities

/2006/ Title X family planning clinics continue to provide family planning services to teens. The DFH's WHSRP continues to provide no cost pregnancy testing and comprehensive health risk assessment to teens receiving pregnancy testing services in Title X clinics. Teens with a negative pregnancy test are linked to family planning services and teens with a positive pregnancy test are referred to the RIDHS's Adolescent Self-Sufficiency Program for pregnant and parenting teens.

Youth In Action continues to provide family planning outreach, education, and referral services to young men living in Providence. Young men in need of family planning services are referred to a Title X site. The state's 9 SBHCs (an additional SBHC was added in FY2005) continue to provide teenagers with access to no cost comprehensive preventive health and mental health services. Teens in need of birth control are referred to a Title X site.

A Teen Pregnancy Prevention Coalition, which is made up of both state and community-based stakeholders, was formed this year. The group is developing a plan to address the need for access to care, primary and secondary prevention strategies, and comprehensive sexuality education. The DFH conducted a number of interviews with key community MCH stakeholders and DFH staff as a part of its efforts to exploring the feasibility of strengthening its current level of maternal health programming. The DFH plans to utilize the reminder of FY2005 and FY2006 to identify and develop strategies for addressing the health needs of adolescent girls, in addition to adult women.

The DFH engaged the services of a student-run consulting group called Youth Infusion, to strengthen the DFH's capacity to involve youth in the development of programs and initiatives. A website for parents of 9-17 year olds and providers was launched. Promotional posters and mailing cards were developed for the website and are distributed to build consumer awareness and utilization. Usability testing and a resulting revision of the site were recently completed.

The DFH continues to support the Men2B Program. Outreach materials continue to be used to increase Men2B enrollment at worksites, schools, and faith-based organizations. A pilot project at the Men's prison at the Rhode Island Department of Corrections (RIDOC) is being implemented for men transitioning back to their families and their communities.

Healthy Schools!/Healthy Kids! issue briefs around a variety of topics, including sexual behavior, were produced from the Youth Risk Behavior Survey (YRBS) and SALT data sources. The briefs were distributed to school administrators to help inform discussions about a variety of health issues, including teenage pregnancy prevention. The DFH's Data & Evaluation Unit continues to track births among teens and examine trends by demographic factors //2006//.

c. Plan for the Coming Year

/2006/ The DFH will continue to provide teens with access to family planning services through Title X sites. The DFH's WHSRP will continue to provide no cost pregnancy testing and comprehensive health risk assessment and follow-up services to teens receiving services in Title X clinics. Youth In Action will continue to provide family planning outreach, education, and referral services young men in Providence. Young men in need of family planning services will be referred to a Title X site. The state's 9 SBHCs will continue to provide teenagers with access to no cost comprehensive preventive health services. Teens in need of birth control will be referred to a Title X site.

The DFH will continue to explore the feasibility of strengthening its current level of maternal health programming. The DFH plans to utilize FY2006 to continue to identify and develop strategies for addressing the health needs of adolescent girls and adult women. The Teen Pregnancy Prevention Coalition will serve a public policy, education and advocacy role with representation from both state and community based stakeholders, including DFH staff. The group will implement strategies to facilitate improvements to adolescent access to care, to both primary and secondary pregnancy prevention efforts, and to implementation of comprehensive school sexuality education.

The DFH, will implement strategies recommended by Youth Infusion to involve youth in the development of programs in FY2006. A website will continue to provide parents of 9-17 year olds and providers with connections to RI programs and resources. The web site will be promoted as part of a coordinated communications strategy to promote the Men2B program, Can We Talk, and Plain Talk in work sites, faith organizations and schools.

The DFH will continue to support the Men 2B Program. Program quality will be a focus of effort and evaluation data will continue to inform improvement. A pilot project at the Men's Adult Correctional Institution implemented for men transitioning back to homes and communities will be evaluated and continued if effective.

Plain Talk is intended to reduce teen birth rates and rates of sexually transmitted diseases. The DFH intends to convene a group to develop a plan to implement a Plain Talk Program in RI's communities. Healthy Schools!/Healthy Kids! will continue to focus on strengthening the infrastructure to support coordinated school health programs and including out-of-school time programming.

The DFH's Data & Evaluation Unit will continue to track births among teens and examine trends by demographic factors. In addition to birth data, data from the Rhode Island Youth Risk Behavior Survey (YRBS) and SALT Survey will continue to be used to look at risk behaviors, after-school activities and time left unsupervised //2006//.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50.5	50.7	51	51.5	51.7
Annual Indicator	47.6	49.4	44.8	48.5	56.7
Numerator	6628	7226	6553	7094	8301
Denominator	13924	14628	14628	14628	14628
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	51.9	52	52.2	52.4	52.4

Notes - 2002

Data are estimated and are based on data provided by the Providence Smiles Program which is an elementary school oral health program operating in ten schools in the city of Providence. The program offers in-classroom oral health education, screenings, oral prophylaxis, fluorial treatments and sealant application. In addition, the program offers referral services for those children in need of more extensive care.

There are ongoing discussions with the RI School for the Deaf to improve the hearing screening activities in preschools and for k-4. The long term goal is to create a joint Health/Education Screening Program.
The effort will begin with hearing and then move to oral and vision.

Notes - 2003

2003: Data are estimated.
Percent reflects third grade children who received sealants or already had sealants on at least one permanent molar tooth.

Data are provided by the Providence Smiles Program which is an elementary school oral health program operating in ten schools in the city of Providence. In 2003 two elementary schools in Pawtucket were added. The program offers in-classroom oral health education, screenings, oral prophylaxis, fluorial treatments and sealant application. In addition, the program offers referral services for those children in need of more extensive care.

Notes - 2004

2004: Data are estimated.
Percent reflects third grade children who received sealants or already had sealants on at least one permanent molar tooth.

Data are provided by the Providence Smiles Program which is an elementary school oral health program operating in ten schools in the city of Providence and several schools in the city of Pawtucket. The program offers in-classroom oral health education, screenings, oral prophylaxis, fluorial treatments and sealant application. In addition, the program offers referral services for those children in need of more extensive care.

a. Last Year's Accomplishments

/2006/ The DFH continued to work to prevent dental caries in children. In FY2004, the DFH supported the education and outreach component of Providence Smiles, which is a school based oral health program operating in 10 Providence elementary schools. Operated by St Joseph Hospital, Providence Smiles utilizes mobile dental teams to provide children with cleanings, fluoride treatments, and dental sealants. It also provides children with education on proper brushing both individually and in the classrooms. Providence Smiles provides the DFH with the data utilized to track this indicator.

Parents of young children receiving home visiting services through the DFH's Family Outreach Program (FOP) continued to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care throughout FY2004.

The DFH's Healthy Child Care Rhode Island Initiative (HCCRI) continued to support activities to ensure that parents of children in childcare had access to culturally and linguistically appropriate informational materials about childhood dental caries and the importance of preventive dental care.

Families receiving DFH WIC services were provided with information about early childhood caries as well. All local WIC staff received technical training on oral health topics in FY2004.

Three of the 7 DFH supported School-Based Health Center (SBHC) sites continued to provide dental services to youth. Two of the sites were located in Pawtucket and one was located in Central Falls. Two of the SBHC sites provided direct oral health services on-site. The other SBHC dental site had to be moved to a local elementary school due to the severity of the students' oral health needs. SBHCS in Providence, Woonsocket, Pawtucket, and Central Falls referred students to dental facilities in the SBHC's parent community health center.

The DFH continued to participate on HEALTH's Oral Health Coordinating Team, which is charged with developing recommendations to improve the oral health of school-age children, including CSHCN. The Oral Health Coordinating Team is managed by HEALTH's Oral Health Program, which is housed in HEALTH's Division of Disease Prevention and Control (DDPC). The DFH also continued to work with Rhode Island Department of Human Services (RIDHS) as it proceeds with plans to restructure the oral health service delivery system for children with Medicaid in Rhode Island.

In FY2004, the RI Oral Health Access Project (a collaboration between the RIDHS, the RI Foundation, and RI KIDS COUNT) announced 14 new grants for three years to increase access to dental care for Medicaid families and individuals with special health care needs (including CSHCN) //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the Family Outreach Program (FOP), which provides culturally and linguistically approriate information and education about early childhood caries and the importance of preventive dental care.	X			

2. Continues to provide families receiving WIC services with culturally and linguistically approriate information and education about early childhood caries and the importance of preventive dental care.	**X**			
3. Participates on the Head Start Oral Health Coalition, which focuses on appropriate referrals for Head Start enrollees to maintain oral health or access needed oral health services.				**X**
4. Ensures that families with children in child care settings have access to culturally and linguistically appropriate oral health information through the Health Child Care Rhode Island Initiative (HCCRI).			**X**	
5. Supports 9 School-Based Health Centers (SBHCS), which provide adolescents with access and/or referrals to oral health services.	**X**			
6. Participates on the RI Department of Health's Oral Health Coordinating Team, which is charged with making recommendations to improve the oral health of school-aged children.				**X**
7. Continues to work with the RI Department of Human Services (RIDHS) as it proceeds with plans to restructure the oral health service delivery system for children enrolled in Medicaid.				**X**
8.				
9.				
10.				

b. Current Activities

/2006/ The DFH continues to work to prevent dental caries in children. Most children at risk for early childhood caries are likely to be of minority race/ethnicity and/or from families with low incomes. Parents of young children receiving home visiting services through the DFH's Family Outreach Program (FOP) receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

Families receiving WIC services are provided with information about early childhood caries as well. All local WIC staff will continue to receive technical training on oral health topics. WIC is a member of Head Start Oral Health Coalition, which was created by HEALTH's Oral Health Program after receiving funding from the federal MCH Bureau to improve access to oral health services for children enrolled in Head Start. Through this grant, HEALTH promotes "common sense" oral health practices for very young children by teaching parents and Head Start providers about early childhood tooth decay prevention. The "common sense" practices include drinking fluoridated water, daily brushing with fluoridated toothpaste, and annual visits to a dentist.

The DFH's Healthy Child Care Initiative (HCCRI) supports activities to ensure that parents of children in child care and childcare providers had access to culturally and linguistically appropriate information about childhood dental caries and the importance of preventive dental care.

Three of the DFH supported SBHCs provide dental services to youth. Two of the sites are located in Pawtucket and one is in Central Falls. Two of the SBHC sites provide direct oral health services on-site. The other SBHC dental site had to be moved to a local elementary school due to the severity of the students' oral health needs. The Providence Community Health Center (PCHC) recently hired a dentist to provide services at the main health center. SBHCS in Woonsocket, Pawtucket, Central Falls, West Warwick, and Providence refer students to dental facilities in the SBHC's parent community health center.

The DFH participates on HEALTH's Oral Health Coordinating Team, which is charged with developing recommendations to improve the oral health of school-age children, including CSHCN. The Team is managed by HEALTH's Oral Health Program, which is housed in HEALTH's DDPC. The Oral Health Program is currently developing an oral health state plan, implementing a coordinated oral disease surveillance system, assessing oral health workforce capacity, promoting water fluoridation management, establishing statewide oral health coalitions, and providing oral health training and technical assistance to community agencies and other partners to facilitate improved oral health access in RI.

The DFH is also working with the RIDHS as it proceeds with plans to restructure the oral health service delivery system for children and families with Medicaid //2006//.

c. Plan for the Coming Year

The DFH will continue to work to prevent dental caries in children by working with other key partners to strengthen the state's dental services infrastructure. Parents of young children who receive home visiting services through the DFH's Family Outreach Program (FOP) will continue to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care. Families receiving WIC services will continue to be provided with culturally and linguistically appropriate information about early childhood caries as well. WIC will continue to be member of the Head Start Oral Health Coalition, which focuses on appropriate referrals for Head Start enrollees to either maintain oral health or access needed oral health services.

Three of the 7 DFH supported SBHCs will continue to provide dental services to youth. SBHCS in Woonsocket, Pawtucket, Central Falls, West Warwick, and Providence will continue to refer students to dental facilities in the parent community health center.

The DFH's Healthy Child Care RI (HCCRI) initiative will continue to support activities to ensure that parents of children in child care and childcare providers had access to culturally and linguistically appropriate information about childhood dental caries and the importance of preventive dental care. HCCRI will also work with HEALTH's Oral Health Coordinating Team to disseminate information about preventive dental care to low-income children in childcare settings.

The DFH will continue to participate on HEALTH's Oral Health Coordinating Team, which is charged with developing recommendations to improve the oral health of school-age children, including CSHCN. The Oral Health Coordinating Team is managed by HEALTH's Oral Health Program, which is housed in HEALTH's DDPC. The Oral Health Program will continue to work on developing an oral health state plan, implementing a coordinated oral disease surveillance system, assessing oral health workforce capacity, promoting water fluoridation management, establishing statewide oral health coalitions, and providing oral health training and technical assistance to community agencies and other partners to facilitate improved oral health access in RI.

The DFH also will also continue to work with the Rhode Island Department of Human Services (RIDHS) as it proceeds with plans to restructure the oral health service delivery system for children and families with Medicaid. The RI Oral Health Access Project (a collaboration between the RIDHS, the RI Foundation, and RI KIDS COUNT) will continue to increase the number of dentists, enabling community health organizations to provide dental services and expand school-based dental exams and treatment during FY2006 ***//2006//.***

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1.5
Annual Indicator	0.5	1.0	1.5	2.1	0.0
Numerator	1	2	3	4	0
Denominator	194971	194965	194965	194965	186874
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

Notes - 2004

2004: Data reflect calendar year. As of 5/2005 there are no deaths to children aged 14 years and younger caused by motor vehicle crashes. However data are provisional. There are 6 cases pending cause of death and out-of-state deaths have not yet been entered.

Denominator is estimated using Statewide Planning numbers for 2005.

a. Last Year's Accomplishments

/2006/ The number of deaths to children ages 14 years and younger caused by motor vehicle crashes in Rhode Island is very small. In FY2002, there were three, in FY2003, there were four, and in FY2004 (provisional data), there were none. The DFH continued to work to reduce the number of deaths to children ages 14 years old and younger caused by motor vehicle crashes.

In FY2004, the DFH's Family Outreach Program (FOP) continued to provide families with young children culturally and linguistically appropriate information regarding the proper use of care seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving FOP home visits were referred to RI Safe Kids, which provides free car seats to low-income families.

The DFH's Healthy Child Care RI (HCCRI) initiative continued to provide culturally and linguistically appropriate informational materials to families with children in childcare and childcare providers on the proper use of care seats, air bag safety, and the safest location in the car for children with children through the Child Care Support Network (CCSN).

Deaths to children ages 14 years old and younger caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in Rhode Island and in the nation. The DFH's Women's Health Screening and

Referral Program (WHSRP) provides free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in nine of the DFH's ten Title X family planning sites. As a part of the WHSRP, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services.

According to SAMHSA, Rhode Island had the 7th highest rate of past month use of any illicit drug use among individuals ages 12 years and older in 2003 (10.95%) among the 50 states and the District of Columbia. It also had the 7th highest rate of binge alcohol use in the past month among individuals ages 12 years and older in 2003 (26.97%) among the 50 states and the District of Columbia. In 2001, 22% of the women who participated in the WHSRP reported that they used alcohol and/or drugs //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the Family Outreach Program (FOP), which provides families with young children with culturally and lingustically appropriate information and education about automobile safety.	X			
2. Refers families to RI Safe Kids, which provides free car seats to low-income families throught the FOP.		X		
3. Provides culturally and linguistically apppropriate information and education to families with children in child care settings about automobile safety through Healthy Child Care Rhode Island (HCCRI).		X		
4. Refers risk positive women who recieve pregancy tests to substance abuse assessment and/or treatment services through the Women's Health Screening & Referral Program (WHSRP).	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2006/ The DFH continues to work to reduce the number of deaths to children ages 14 years old and younger caused by motor vehicle crashes. The number of deaths to children ages 14 years and younger caused by motor vehicle crashes in Rhode Island is very small. In FY2002, there were three, in FY2003, there were four, and in FY2004 (provisional data), there were none.

In FY2005, the DFH's Family Outreach Program (FOP) continues to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving FOP home visits continue to be referred to RI Safe Kids, which provides culturally and linguistically appropriate printed informational materials to the public and free car seats to low-income families.

The DFH's Healthy Child Care RI (HCCRI) initiative continues to provide culturally and linguistically appropriate informational materials regarding the proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers through the Child Care Support Network (CCSN).

Deaths to children ages 14 years old and younger caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in Rhode Island and in the nation. The DFH's Women's Health Screening and Referral Program (WHSRP) continues to provide free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in nine of the DFH's ten Title X family planning sites. As a part of the WHSRP, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services.

According to SAMHSA, Rhode Island had the 7th highest rate of past month use of any illicit drug use among individuals ages 12 years and older in 2003 (10.95%) among the 50 states and the District of Columbia. It also had the 7th highest rate of binge alcohol use in the past month among individuals ages 12 years and older in 2003 (26.97%) among the 50 states and the District of Columbia. In 2001, 22% of the women who participated in the WHSRP reported that they used alcohol and/or drugs //2006//.

c. Plan for the Coming Year

/2006/ The DFH will continue to work to reduce the number of deaths to children ages 14 years old and younger caused by motor vehicle crashes. The number of deaths to children ages 14 years and younger caused by motor vehicle crashes in Rhode Island is very small. In FY2002, there were three, in FY2003, there were four, and in FY2004 (provisional data), there were none.

In FY2006, the DFH's Family Outreach Program (FOP) will continue to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving FOP home visits will continue to be referred to RI Safe Kids, which provides culturally and linguistically appropriate printed informational materials to the public and free car seats to low-income families.

The DFH's Healthy Child Care RI (HCCRI) initiative will continue to provide culturally and linguistically appropriate informational materials regarding the proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers through the Child Care Support Network (CCSN). HCCRI will focus particularly on family home childcare providers during FY2006.

Deaths to children ages 14 years old and younger caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in Rhode Island and in the nation. The DFH's Women's Health Screening and Referral Program (WHSRP) will continue to provide free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in nine of the DFH's ten Title X family planning sites. As a part of the WHSRP, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services.

According to SAMHSA, Rhode Island had the 7th highest rate of past month use of any illicit drug use among individuals ages 12 years and older in 2003 (10.95%) among the 50 states and the District of Columbia. It also had the 7th highest rate of binge alcohol use

in the past month among individuals ages 12 years and older in 2003 (26.97%) among the 50 states and the District of Columbia. In 2001, 22% of the women who participated in the WHSRP reported that they used alcohol and/or drugs //2006//.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	60.2	60.5	60.7	60.7	61
Annual Indicator	56.5	57.0	57.7	57.6	56.4
Numerator	6831	6956	7189	7295	6945
Denominator	12090	12213	12459	12662	12324
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61	61.3	61.3	61.3	61.3

Notes - 2002

Data reflect calendar year and for "breastfeeding only". Does not include if breastfeeding and bottle feeding were combined.

Since breastfeeding is captured through the Newborn Developmental Risk Assessment Screening Program, data reflect Rhode Island resident births born in Rhode Island.

There are between 300 - 500 records where breastfeeding type is unknown per year. Starting with 2002, total unknowns are excluded from the denominator.

Notes - 2003

Data reflect calendar year and for "breastfeeding only". Does not include if breastfeeding and bottle feeding were combined.

Since breastfeeding is captured through the Newborn Developmental Risk Assessment Screening Program, data reflect Rhode Island resident births born in Rhode Island.

There are between 300 - 500 records where breastfeeding type is unknown per year. Starting with 2002, total unknowns are excluded from the denominator.

Notes - 2004

Data reflect calendar year and for "breastfeeding only". Does not include if breastfeeding and bottle feeding were combined.

Since breastfeeding is captured through the Newborn Developmental Risk Assessment Screening Program, data reflect Rhode Island resident births born in Rhode Island.

There are between 300 - 500 records where breastfeeding type is unknown per year. Starting with 2002, total unknowns are excluded from the denominator.

a. Last Year's Accomplishments

/2005/ The DFH continued to work to increase the percentage of mothers who breastfeed their infants at hospital discharge //2005//. ***/2006/ In FY2004, the DFH's WIC Program continued to support the Tender Loving Care (TLC) lactation support program for WIC participants six days a week in birthing hospitals. It also continued to support a "mother-to-mother" peer-counseling program to provide culturally competent breastfeeding support to WIC participants at up to 17 sites.***

In FY2004, the DFH maintained partnerships with the RI Breastfeeding Coalition (RIBC) and the Physicians' Committee for Breastfeeding in RI and collaborated with these groups to develop a statewide breastfeeding promotion plan. The WIC Program hosted a statewide conference to engage local providers in this planning process through a USDA grant. The plan involves worksites and insurers in program development to support breastfeeding mothers and to place culturally and linguistically appropriate campaign materials in the media and in provider's offices, with a special emphasis on low-income women and women from diverse cultures.

In FY2004, the WIC Program continued to support World Breastfeeding Month, by using USDA funds to purchase advertising space in movie theaters, on buses, and at a minor league ballpark to promote breastfeeding. These efforts complemented a wider breastfeeding promotion campaign that Rhode Island is partnering on with the USDHHS. The WIC Program also provided the local WIC agencies with special funds to purchase sustainable breastfeeding promotion materials and to sponsor breastfeeding promotion events at their clinics.

In collaboration with the Rhode Island Breastfeeding Coalition, a breastfeeding tips and resources brochure was developed in English and Spanish for distribution to breastfeeding mothers at hospital discharge. Guidelines for handling breast milk and supporting breastfeeding mothers were also developed and were distributed to local childcare providers. The DFH conducted formative research with employers, which will be used to develop breastfeeding promotion materials for the workplace //2006//.

/2005/ The DFH's Communications unit also continued to support the toll-free Family Health Information Line. Bilingual (English & Spanish) staff continued to take calls from breastfeeding women and refer them to appropriate community resources, in accordance with the DFH's breastfeeding protocol. The DFH's centralized Distribution Center continued to provide agencies and breastfeeding women with culturally and linguistically appropriate printed informational brochures on breastfeeding //2005//.

/2006/ KIDSNET continued to track the percentage of mothers who breastfeed and the percentage of mothers who formula feed their infants through Family Outreach Program FOP and Level I data. RIPRAMS surveyed new mothers on the topic of breastfeeding. The DFH's Data & Evaluation Unit continued to track breastfeeding rates from multiple sources//2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the TLC lactation support program for WIC participants in the state's birthing hospitals.	X			
2. Continues to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants in 16 sites.	X			
3. Continues to promote "World Breasfeeding Month" throught the local media, in public libraries, and in local WIC sites.			X	
4. Continues to develop and implement a statewide breasfeeding promotion plan, focusing on worksites and insurers, in collaboration with key partners.				X
5. Continues to disemminate culturally and linguistically appropriate breastfeeding informational materials targeting low-income families in the media and in provider's offices.			X	
6. Developed and distributed a breastfeeding pocket guide for health care and child care providers.		X		
7. Is in the process of revising and updating a culturally competent RI Breasfeeding Resource Directory.			X	
8. Developed and maintains the RI Department of Health's website on breastfeeding for families, worksites, and professionals.			X	
9. Continues to support the toll-free bi-lingual Family Health Information Line which refers breastfeeding callers to appproriate community resources.		X		
10. Collects and tracks breasfeeding information through FOP, PRAMS, and TWOS data.			X	

b. Current Activities

/2005/ The DFH continues to work to increase the percentage of mothers who breastfeed their infants at hospital discharge//2005//. ***/2006/ The WIC Program supports the Tender Loving Care (TLC) lactation support program for WIC participants six days a week in birthing hospitals. WIC continues to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants at 16 sites and trained seven new peer counselors to cover an additional seven sites.***

In FY2005, WIC will promote World Breastfeeding Month through the local media, in public libraries and at local WIC sites. The DFH, the RI Breastfeeding Coalition (RIBFC) and the Physicians' Committee for Breastfeeding in RI are carrying out carry out the activities in the statewide plan. The engages worksites and insurers in program development to support breastfeeding mothers and to place culturally and linguistically appropriate campaign materials in the media and in provider's offices, with a special emphasis on low-income women and women from diverse cultures.

The WIC Program and the Communications Unit continues to develop culturally and linguistically appropriate materials. A breastfeeding wallet card was developed in English and Spanish to distribute to breastfeeding mothers and a breastfeeding pocket guide was developed and distributed to providers. The breastfeeding tips and resources brochure and guidelines for childcare providers continue to be distributed. The DFH has developed and launched a website for parents and health care providers. In addition, the RI Breastfeeding Resource Directory will be revised during FY2005.

The DFH's Communications unit continues to support the toll-free Family Health Information Line. Bilingual Family Health Information Line staff members take calls from breastfeeding women and refer them to appropriate community resources. The DFH's centralized Distribution Center provides culturally and linguistically appropriate printed informational brochures on breastfeeding. KIDSNET tracks the percentage of mothers who breastfeed and the percentage of mothers who formula feed their infants through FOP data. Families with infants who receive FOP home visiting services receive culturally and linguistically appropriate information and support on the topic of breastfeeding, including referrals to breastfeeding support services.

RI PRAMS continues to survey new mothers on the topic of breastfeeding. Data show that over two-thirds (69.6%) of respondents who gave birth in 2002 and 2003 indicated that they ever breastfed and 36.8% of those mothers were still breastfeeding at the time of the survey (2-4 months post delivery).

The DFH has developed a follow-up survey for PRAMS respondents that agree to be recontacted in two years. TWOS will provide information on the duration of breastfeeding. TWOS was implemented in March 2005//2006//.

c. Plan for the Coming Year

/2005/ The DFH will continue to work to increase the percentage of mothers who breastfeed their infants at hospital discharge //2005//. ***/2006/ In FY2006, the DFH's WIC Program will continue to support the Tender Loving Care (TLC) lactation support program for WIC participants six days a week in birthing hospitals and will continue to implement and monitor program changes. The WIC Program will provide technical training to WIC staff to respond to clients' breastfeeding concerns and will research and attempt to establish a statewide breast pump rental program.***

The WIC Program will continue to support World Breastfeeding Month to encourage women to breastfeed their infants. In FY2006, the DFH will continue to partner with the RIBC and the Physicians' Committee on Breastfeeding in RI and other health care organizations to implement the statewide breastfeeding promotion plan. The plan will continue to engage worksites and insurers in program development to support breastfeeding mothers and to place linguistically and culturally appropriate campaign materials in the media and in provider's offices, with a special emphasis on low-income women and women from diverse cultures.

Based on formative research conducted in FY2004, the DFH will purchase and personalize breastfeeding promotion materials developed by the US MCH Bureau for distribution to worksites in FY2006. In addition, DFH will establish a mechanism for recognizing breastfeeding-friendly worksites (e.g. awards and advertisements in business journals). Breastfeeding information will be integrated into a packet of prenatal materials to be distributed to prenatal care providers.

KIDSNET will continue to track the percentage of mothers who breastfeed and the percentage of mothers who formula feed their infants through FOP data. Families with infants who receive FOP home visiting services will continue to receive culturally and linguistically appropriate information and support on the topic of breastfeeding, including referrals to breastfeeding support services. The DFH will continue to collect information on intended feeding practices at the time of hospital discharge as a part of the Level I screening process.

The DFH's Communication Unit will continue to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including breastfeeding support services. Culturally and linguistically appropriate informational materials will continue to be distributed through the DFH's centralized Distribution Center.

RI PRAMS will continue to survey recent mothers on the topic of breastfeeding (PRAMS includes 5 questions related to breastfeeding). TWOS will continue to survey mothers of two-year olds and obtain information on breastfeeding in addition to other topics //2006//.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	99.7	99.3	99.3	99.3
Annual Indicator	99.7	99.3	99.4	99.6	99.6
Numerator	13140	13134	13421	13705	13468
Denominator	13180	13232	13498	13763	13521
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	99.5	99.5	99.6	99.6

Notes - 2002

Data reflect births occurring in Rhode Island and should be considered estimated. VLBW infants that died within days or infants that died within hours are excluded from the denominator.
Data for 2001 and 2002 were provided by Rhode Island Hearing Assessment Program [RIHAP]. The RIHAP system places in-patient screening and screening within one month of age in the same category. RIHAP is in the process of upgrading their program in order to capture missed opportunities [infants not screened prior to discharge]. However, other RIHAP data, strongly supports the fact that at least 99% of infants born in RI are screened prior to discharge.

Notes - 2004

Data reflect births occurring in Rhode Island and should be considered estimated. VLBW infants that died within days or infants that died within hours are excluded from the

denominator.
Data for 2001 thru 2004 were provided by Rhode Island Hearing Assessment Program [RIHAP].

a. Last Year's Accomplishments

/2005/ The DFH continued to work to reduce the morbidity associated with hearing impairment through early detection //2005//. ***/2006/ In FY2004, the DFH's RI Hearing & Assessment Program (RIHAP) continued to ensure that all newborns received hearing screening prior to hospital discharge //2006//***. /2005/ The DFH continued to utilize KIDSNET to track RIHAP screening information, which originates through the DFH's newborn screening process //2005//. ***/2006/ During FY2004, the newborn hearing screening data system, RITRACK, underwent a major upgrade. Not only is the new system more user friendly, it greatly increases the number and quality of data elements, which can be used for tracking and quality assurance.***

The DFH's Newborn Screening Program and Communications Unit collaborated to develop integrated culturally and linguistically appropriate informing brochures (prenatal, perinatal, and postnatal) for families that includes bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. The development of the materials was based on survey and focus group results with families. Prototypes of the draft brochures were field tested. Modifications based on the field test were made prior to translation into Spanish.

A web-based version of KIDSNET became available in FY2004 and will pave the way for connecting audiologists to KIDSNET information related to newborn hearing screening and follow-up and for school nurse teachers to access school hearing screening follow-up information. A list of pediatric audiologists in the state was previously compiled. Gaps in equipment needed to comply with pediatric audiology guidelines identified through the DFH's HRSA "First Connections" grant have been completely filled, improving the availability of pediatric audiology services throughout the state.

Printing of a flow chart, or algorithm, for primary care providers of infants who were referred from the DFH for diagnostic hearing testing that was developed by modifying a document produced by the American Academy of Pediatrics (AAP) and the "EHDI" community was completed. A distribution plan for the algorithm was developed and implemented. A grant was secured to link school hearing data to KIDSNET. The hope is to better facilitate tracking, diagnostic audiology, and follow-up of school-age children who do not pass their hearing screening tests.

The DFH's RIPRAMS continued to collect data on parental awareness that babies are tested in the hospital for hearing loss. The DFH's Birth Defects Program, in conjunction with the Birth Defects Advisory Council, included hearing loss as one of the program's "sentinel conditions". Children identified with these conditions will be followed to determine whether they received appropriate services and referrals//2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Ensures universal newborn hearing screening prior to hospital discharge.				X
2. Utilizes KIDSNET to track RI Hearing Assessment Program (RIHAP) hearing screening information, which originates through the DFH's integrated Level I newborn screening process.				X
3. Ensures that infants identified with hearing impairment are referred to the RI School for the Deaf and Early Intervention by RIHAP.				X
4. Continues to support the Family Outreach Program (FOP), which tracks infants lost to follow-up by RIHAP.				X
5. Utilizes KIDSNET to identify newborns born the previous month who do not have a hearing screening result in KIDSNET, which are referred to RIHAP for follow-up.				X
6. Continues to work to link school hearing data into KIDSNET, which will facillitate tracking, diagnosis, and follow-up of school-aged children with hearing impairments.				X
7. Has made a web-based version of KIDNET accessible to pediatric providers, school nurse teachers, Head Starts, audiologists, and 27 school districts.				X
8. Continues to work to ensure that a final diagnosis of hearing impairment is recorded and reported to the DFH's Birth Defects Program.				X
9. Continues to collect and analyze information on family awareness about newborn hearing screening through PRAMS.			X	
10. Developed integrated cultually and linguistically appropriate informing bochures that include hearing, based on survey and focus group results.			X	

b. Current Activities

/2005/ RIHAP ensures that all newborns received hearing screening prior to hospital discharge. The DFH utilizes KIDSNET to track RIHAP screening information, which originates through the DFH's newborn screening process. Infants who are identified with hearing impairment are referred to the RI School for the Deaf's Family Guidance Program and EI. FOP home visitors also continue to track infants who are lost to follow-up by RIHAP //2005//.

/2006/ KIDNET has the capacity to run a monthly report developed a report that indicates which children born in the previous month do not have a hearing screening result in KIDSNET //2006//. /2005/ RIHAP then follows up to identify whether the child was missed or if the data was never entered into KIDSNET. The DFH has begun to work on linking the newborn hearing screening data with other newborn data. This includes plans for pre-populating the newborn hearing screening database with birth information collected on a new, integrated newborn developmental risk assessment and birth certificate system. This will ensure that all babies get screened for hearing impairment //2005//.

/2006/ The Newborn Screening Program continues to work with an SSD grant to link school hearing data to KIDSNET. Since primary care providers, school nurse teachers, and audiologists all have access and/or are working with KIDSNET, the hope is to better facilitate tracking, diagnostic audiology, and follow-up of school-age children who do not pass their hearing screening tests //2006//.

/2005/A flow chart, or algorithm, for primary care providers of infants who were referred from the DFH for diagnostic hearing testing was developed by modifying a document produced by the AAP and the "EHDI" community //2005//. ***/2006/Ongoing distribution will be made to primary care providers with hearing screening results needing follow-up //2006//***.

/2005/ Draft informing brochures have been developed by the DFH, based on survey and focus group results. An integrated informing approach was used and includes bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET //2005//. ***/2006/ The DFH will print and develop a strategy to distribute the informing brochures to prenatal, hospital, and pediatric health providers.***

The DFH's Birth Defects Program will continue to work with the DFH's Newborn Screening Program to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the Birth Defects Program.

RI PRAMS continues to collect data on parental awareness that babies are tested in the hospital for hearing loss. Nearly 3 out of 4 respondents (73.7%) who delivered during 2002 and 2003 indicated that they were aware that babies are tested in the hospital for hearing loss. In FY2003, 92.26% of non-Hispanic respondents were aware of newborn screening compared to 71.68% of Hispanic respondents //2006//.

c. Plan for the Coming Year

/2005/ RIHAP will ensure that all newborns received hearing screening prior to hospital discharge. The DFH will utilize KIDSNET to track RIHAP screening information, which originates through the DFH's newborn screening process. Infants who are identified with hearing impairment will continue to be referred to the RI School for the Deaf and to EI. FOP home visitors will also continue to track infants who are lost to follow-up by RIHAP.

KIDSNET will continue to send a report to RIHAP monthly. The report indicates which children born in the previous month do not have a hearing screening result in KIDSNET. RIHAP will continue to follow up to identify whether the child was missed or if the data was never entered into KIDSNET //2005//. ***/2006/ KIDSNET will utilize FY2006 to make its web version of KIDSNET available to all audiologists //2006//***. /2005/ Also, KIDSNET will look into the possibility of obtaining school late onset hearing results in addition to newborn hearing screening results//2005//.

/2006/The Communication Unit, in collaboration with the DFH's Newborn Screening Program, developed an integrated informing strategy targeting families about newborn screening programs, including RIHAP. Formative research conducted in 2003 guided the development and implementation of the informing strategy. During FY2006, the DFH will print and develop a strategy to distribute the informing brochures to prenatal, hospital, and pediatric health care providers. The goal is to assure that the providers understand their role in the newborn screening informing process, routinely give materials to their patients, and answer questions form their patients.

During FY2006, the school hearing screening data system ill be implemented for the 2006/2007 school year under an SSDI grant to link school hearing data to KIDSNET. Since primary care providers, school nurse teachers, and audiologists all have access and are working with KIDSNET, the hope is to better facilitate tracking, diagnostic audiology, and follow-up of school-age children who fail their hearing screening. Ongoing exploration of FERPA and potential collaborations with RINET, the state's education data system, will also take place in FY2006.

Building on the newborn hearing screening algorithm developed for primary care providers, a similar process, which focuses on needs of families, will be followed to develop an algorithm or other materials that will help families understand the system for follow-up in Rhode Island. All materials and letters used in the program will be translated into Spanish. The HEALTH and RIHAP websites will be upgraded and improved.

The DFH's Birth Defects Program will continue to work with the Newborn Screening Program to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the DFH. In addition, PRAMS will continue to survey new mothers regarding parental knowledge that babies are tested in the hospital for hearing loss //2006//.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5	5	5	4.7	4.7
Annual Indicator	3.8	4.5	4.7	5.2	5.6
Numerator	9417	11152	11648	12890	13878
Denominator	247822	247822	247822	247822	247822
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.4	5.6	5.6	5.7	5.7

Notes - 2002

Data from US Census Bureau March Current Population Survey [CPS]. Data have been revised and now reflect percentages reported by CPS.

Notes - 2003

Data is from US Census Bureau March Current Population Survey [CPS].

Notes - 2004

Data is from US Census Bureau March Current Population Survey [CPS]. Data for 2004are not yet available and therefore, are estimated.

a. Last Year's Accomplishments

/2006/The DFH continued to work to ensure access to needed and continuous health care services for children. The DFH continued to support culturally diverse Family Resource Counselors (FRCs) in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care. The DFH continued to provide training to FRCs through quarterly meetings, special topics trainings, and on-site technical assistance.

Family Health Information Line information specialists and DFH parent consultants continued to receive training about RIte Care and assisted with outreach activities. Family Health Information Line Staff continued to refer callers without health insurance

to RIte Care and referred them to FRCs in the community for further assistance in completing applications. DFH parent consultants continued to provide information about RIte Care in numerous schools, childcare centers, health fairs, and community agencies. DFH FOP home visitors continued to help families fill out RIte Care enrollment forms and put them in touch with FRCs, who helped them complete the enrollment process. The DFH's Healthy Child Care RI Initiative (HCCRI) continued to utilize childcare settings throughout the state to outreach to families potentially eligible for RIte Care.

The DFH's Ready to Learn Providence (RLP), Newport County CATCH, Mt. Hope CATCH, and Washington County CATCH systems development investments continued to support community assessment and planning activities designed to increase utilization of maternal & child health services, including RIte Care. Ensuring that eligible families are enrolled in RIte Care represents an important part of the DFH's work in this area. The DFH's Successful Start initiative, engaged in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system, including ensuring that all children have access to needed and continuous health care services. Ongoing family input and cultural competency represented important components of this initiative.

The DFH's Pediatric Practice Enhancement Project (PPEP) assisted over 300 families with CSHCN in 2004 on issues concerning insurance, education, and access to mental health services. Almost 25% of these families required direct assistance in accessing health insurance.

RI PRAMS surveyed women 2-4 months after delivery and asked about their baby's health insurance status. This information will be used to assess whether women have different access experiences based on their health insurance status. The DFH's Toddler Wellness Overview survey (TWOS) was developed to survey PRAMS respondents who agree to be re-contacted when their child turns two years of age. TWOS includes questions regarding health insurance//2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supports culturally diverse Family Resource Counselors (FRCS) in 20 community health center sites and 4 hospitals to identify and enroll families onto RIte Care.				X
2. Continues to support the toll-free bilingual Family Health Information Line which refers families without health insurance to Rite Care and/or FRCs for further help with the Rite Care application process.		X		
3. Continues to support culturally diverse parent consultants to provide information about RIte Care at health fairs and in schools, child care settings, community-based agencies, and other forums.				X
4. Continues to support culturally diverse Family Outreach Program (FOP) home visitors, which refer pregnant women and families with young with children to RIte Care and FRCs.	X			
5. Utilizes the Pediatric Practice Enhancement Project (PPEP) to identify and refer families with CSHCN to Rite Care, SSI, and Katie Beckett.				X
6. Continues to support the Ready to Learn Providence (RLP) and				

RIAAP CATCH systems development investments to identify and refer families with young children onto RIte Care.				X
7. Continues to support the statewide early childhood systems development initiative Successful Start to identify and refer families with young children onto RIte Care.				X
8. Refers children without health insurance who are ineligble for RIte Care to no cost lead screening and immunization clinics.	X			
9. Continues to survey new mothers through PRAMS to determine health insurance coverage status.			X	
10. Is surveying mothers of two-year olds through TWOS to determine health insurance coverage status.			X	

b. Current Activities

/2006/ The DFH is working to ensure access to needed and continuous health care services for children. The DFH supports culturally diverse FRCs in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care. The RIHCA now has an expanded contract through RIDHS, which supports intensive technical assistance, training, and quality assurance for the FRC Program.

Family Health Information Line information specialists and DFH parent consultants continue to receive training about RIte Care and assist with outreach activities. The DFH refers callers without health insurance to RIte Care and FRCs for further assistance in completing applications. DFH parent consultants provide information about RIte Care in numerous schools, childcare centers, health fairs, and CBOs.

FOP home visitors help families fill out RIte Care enrollment forms and put them in touch with FRCs, who helped them complete the enrollment process. HCCRI utilizes childcare settings throughout the state to outreach to families potentially eligible for RIte Care. The DFH continues to provide lead screening and immunizations to uninsured children who are ineligible for Rite Care.

The DFH's Pediatric Practice enhancement Project (PPEP) refers potentially eligible families to fee-for-service Medicaid, SSI, and Katie Beckett. The PPEP assists families with CSHCN on issues concerning insurance, education, and mental health services. PPEP parent consultants are trained on community resources, including all forms of public assistance.

The Ready to Learn Providence (RLP), Mt. Hope CATCH, Washington County CATCH, and Newport County CATCH investments continue to support community assessment and planning activities designed to increase utilization of MCH services, including RIte Care. These plans focus on issues related to "medical homes" and care coordination. Ensuring that eligible families are enrolled in RIte Care represents an important part of the DFH's work in this area. The DFH's Successful Start initiative engaged in a two-year planning project. This planning process resulted in a strategic plan to create positive systemic statewide change around the five components. In FY2006, Successful Start will implement the strategic plan.

RI PRAMS data have been analyzed to determine health insurance coverage among who gave birth during 2002 and 2003 and among their babies. Data indicate that 4.7% of respondents indicated that they did not have health insurance for their baby. Of those that did have health insurance for their baby, Medicaid or RIte Care covered 48.9%. The DFH's Toddler Wellness Overview Survey (TWOS) was implemented in March 2005 and data, including insurance type, are currently being collected. Approximately 1,100 women will be surveyed annually //2006//.

c. Plan for the Coming Year

/2006/ Much of the DFH's work in this area will continue to center on ensuring that eligible families are enrolled in RIte Care and other financial assistance programs. The DFH will support FRCs in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care, WIC, Food Stamps, the Family Independence Program (FIP), and the Childcare Subsidy Program. The Rhode Island Health Center Association (RIHCA) now has an expanded contract through RIDHS, which supports TA, training, and QA for the FRC Program.

Family Health Information Line information specialists will refer callers without health insurance to RIte Care and refer them to FRCs for further assistance in completing applications. DFH parent consultants will provide information about RIte Care in numerous schools, childcare centers, health fairs, and CBOs.

FOP home visitors help families fill out RIte Care enrollment forms and put them in touch with FRCs, who help them complete the enrollment process. HCCRI will utilize childcare settings throughout the state to outreach to families potentially eligible for RIte Care. DFH parent consultants will continue to be members of the RIDHS's RIte Care Consumer Advisory Committee. The DFH's Pediatric Practice Enhancement Project (PPEP) parent consultants will continue to be trained on Rhode Island's public assistance programs.

Ready to Learn Providence (RLP), Newport County CATCH, Washington County CATCH, and Mt. Hope CATCH will support community assessment and planning activities designed to increase utilization of MCH services, including RIte Care This will include "medical home" training and technical assistance for medical providers, local social service agencies, and parents. CATCH projects and RLP will increase their health education efforts directed at parents around specific topics, including asthma, diabetes, and obesity. Successful Start engaged in a two-year planning project. This planning process resulted in a strategic plan to create positive systemic statewide change around the five components. In FY2006, Successful Start will implement the strategic plan.

RI PRAMS will continue to survey women and ask about their baby's health insurance status and analyze the survey data to get a better understanding of the needs of uninsured women who have babies. The DFH's TWOS initiative will continue to survey mothers of three year olds and obtain information on children's health insurance. The DFH's Data & Evaluation Unit will continue to analyze data from the National Survey of Children's Health to determine insurance coverage among children in Rhode Island //2006//.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	85	87	86.7	86.9	86.5

Objective					
Annual Indicator	80.8	86.7	88.8	86.5	85.9
Numerator	79738	84485	87218	89628	91638
Denominator	98738	97485	98218	103628	106638
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.5	86.9	86.9	86.9	86.9

Notes - 2002

Data are estimated and FY96-FY98 reflect children aged <18 .
From FY99, NPM #14 reflects children aged <19.
Targets for 2001-2005 have been lowered to reflect previous years' trend.

Notes - 2003

From FY99, NPM #14 reflects children aged <19; data were provided by the Department of Human Services and the US census.

Notes - 2004

NPM #14 reflects children aged <19. Data were provided by the Department of Human Services and reported in 2005 Rhode Island Kids Count Factbook.

a. Last Year's Accomplishments

/2006/ The DFH worked to enroll all Medicaid-eligible children in Medicaid to ensure better access to health care systems. Much of the DFH's work in this area in FY2004 continued to center on ensuring that eligible families are enrolled in RIte Care and other state-sponsored financial assistance programs. The DFH supported culturally diverse Family Resource Counselors (FRCs) in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care. The DFH provided training to FRCs through quarterly meetings, special topics trainings, and on-site technical assistance. Training was provided in collaboration with the RI Department of Human Services (RIDHS) and Covering KIDS RI.

Bi-lingual DFH Family Health Information Line information specialists referred callers without health insurance to RIte Care and referred them to FRCs in the community for further assistance in completing an application. DFH parent consultants provided information about RIte Care in numerous schools, childcare centers, health fairs, and community agencies throughout RI.

The DFH's Family Outreach Program (FOP) home visitors helped families fill out RIte Care enrollment forms and put them in touch with FRCs, who helped them complete the enrollment process. The DFH's Healthy Child Care RI (HCCRI) initiative utilized childcare settings throughout the state to outreach to families potentially eligible for RIte Care.

Ready to Learn Providence (RLP), Newport County CATCH, Washington County CATCH, and Mt. Hope CATCH systems development initiatives supported community assessment and planning activities designed to increase utilization of maternal & child health services, including RIte Care. RLP, Newport County CATCH, Washington County CATCH, and Mt. Hope CATCH plans focus on issues related to "medical homes" and care coordination. Ensuring that eligible families are enrolled in RIte Care represents an important part of the DFH's work in this area.

The DFH's state early childhood comprehensive systems development initiative, Successful Start, engaged in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system. The 5 components were: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including ensuring that all Medicaid-eligible children are enrolled in Medicaid. Ongoing family input and cultural competency represented important components of this initiative.

During FY2004, the DFH's RI PRAMS surveyed approximately 2,000 women 2-4 months post delivery and asked about their health insurance status //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supports culturally diverse Family Resource Counselors (FRCS) in 20 community health center sites and 4 hospitals to identify and enroll families onto RIte Care.				X
2. Continues to support the toll-free bilingual Family Health Information Line which refers families without health insurance to Rite Care and/or FRCs for further help with the Rite Care application process.		X		
3. Continues to support culturally diverse parent consultants to provide information about RIte Care at health fairs and in schools, child care settings, community-based agencies, and other forums.				X
4. Utilizes the Pediatric Practice Enhancement Project (PPEP) to identify and refer families with CSHCN to Rite Care, SSI, and Katie Beckett.				X
5. Continues to support the Ready to Learn Providence (RLP) and RIAAP CATCH systems development investments to identify and refer families with young children onto RIte Care.				X
6. Continues to support the statewide early childhood systems development initiative Successful Start to identify and refer families with young children onto RIte Care.				X
7. Continues to support culturally diverse Family Outreach Program (FOP) home visitors, which refer pregnant women and families with young with children to RIte Care and FRCs.		X		
8. Continues to refer families with children in child care settings to RIte Care through the Healthy Child care Rhode Island Initiative (HCCRI).		X		
9. Continues to survey new mothers through PRAMS to determine health insurance coverage status.			X	
10. Is surveying mothers of two-year olds through TWOS to determine health insurance coverage status			X	

b. Current Activities

/2006/ The DFH is working to enroll all Medicaid-eligible children in Medicaid to ensuring better access to health care. Much of the DFH's work in this area in FY2005 continues to center on ensuring that eligible families are enrolled in RIte Care and other state-sponsored financial assistance programs. The DFH is supporting culturally diverse

FRCs in 20 health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care.

Bi-lingual DFH Family Health Information Line information specialists refer callers without health insurance to RIte Care and refer them to FRCs in the community for further assistance in completing an application. DFH parent consultants are providing information about RIte Care in numerous schools, childcare centers, health fairs, and community agencies throughout RI.

The DFH's FOP home visitors help families fill out RIte Care enrollment forms and put them in touch with FRCs, who help them complete the enrollment process. The DFH's Pediatric Practice Enhancement Project (PPEP) parent consultants continues to be trained about fee-for-service Medicaid, SSI, and Katie Beckett and continued to refer families to these resources for appropriate follow-up. The DFH's Healthy Childcare Rhode Island Initiative (HCCRI) is utilizing childcare settings throughout the state to outreach to families potentially eligible for RIte Care.

Ready to Learn Providence (RLP), Newport County CATCH, Washington County CATCH, and Mt. Hope CATCH systems development investments support community assessment and planning activities designed to increase utilization of maternal & child health services, including RIte Care. Washington County CATCH is developing strategies to improve the local system of mental health services for children.

The DFH's state early childhood comprehensive systems development initiative, Successful Start, engaged in a two-year planning project to assess capacity, quality, and integration issues surrounding 5 core components of the state's early childhood system. The 5 components are: "medical home", social and emotional development, childcare, parenting education, and family support for all children, including ensuring that all Medicaid-eligible children are enrolled in Medicaid. This planning process resulted in a strategic plan to create positive systemic statewide change around the five components. In FY2006, Successful Start will implement the strategic plan. Ongoing family input and cultural competency represent important components of Successful Start.

RI PRAMS data have been analyzed to determine health insurance coverage among women and their babies among women who gave birth in 2002 and 2003. Data indicate that 4.7% of respondents indicated that they did not have health insurance for their baby. Of those that did have health insurance for their baby, 48.9% were covered by Medicaid or RIte Care. The TWOS initiative began surveying mothers of 2-year olds in FY2005 //2006//.

c. Plan for the Coming Year

/2006/ The DFH will work to enroll all Medicaid-eligible children in Medicaid to ensure better access to health care. The DFH will support culturally diverse Family Resource Counselors (FRCs) in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care.

Bi-lingual DFH Family Health Information Line information specialists will refer callers without health insurance to RIte Care and refer them to FRCs in the community for further assistance in completing an application. DFH parent consultants will provide information about RIte Care in schools, childcare centers, health fairs, and community agencies. DFH parent consultants will continue to be members of the RIDHS's RIte Care Consumer Advisory Committee.

The DFH's Family Outreach Program (FOP) home visitors will help families fill out RIte Care enrollment forms and put them in touch with FRCs, who help them complete the enrollment process. The DFH's Pediatric Practice Enhancement Project (PPEP) parent consultants will continue to be trained about fee-for-service Medicaid, SSI, and Katie Beckett and continued to refer families to these resources for appropriate follow-up. The DFH's Healthy Child Care Initiative (HCCRI) will continue to utilize childcare settings to outreach to families potentially eligible for RIte Care.

Ready to Learn Providence (RLP), Newport County CATCH, Washington County Catch, and Mt. Hope CATCH systems development investments will continue to support community assessment and implementation activities designed to increase utilization of MCH services, including RIte Care. Successful Start engaged in a two-year planning process to assess capacity, quality, and integration issues surrounding five core components of the state's early childhood system and included efforts to ensure that all Medicaid-eligible children are enrolled in Medicaid. This planning process resulted in a strategic plan to create positive systemic statewide change around the five components. In FY2006, Successful Start will implement the strategic plan. Ongoing family input and cultural competency will continue to represent an important part of this initiative as the plan is implemented.

RI PRAMS will continue to survey women and ask about their baby's health insurance status. RI PRAMS data will continue to be analyzed to better understand issues such as health insurance status and access to services //2006//.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1.2	1.5	1.5
Annual Indicator	1.6	1.5	1.8	1.8	1.5
Numerator	194	193	229	238	186
Denominator	12498	12710	12895	13200	12309
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.5	1.5	1.5	1.3	1.3

Notes - 2004

2004 data are provisional and will be updated when out of state events for Rhode Island Residents are received.

a. Last Year's Accomplishments

/2006/ The DFH continued to work to reduce the proportion of all live deliveries with very low birth weight. The DFH continued to support the Title X Family Planning Program, which received additional federal Title X funds to expand HIV counseling, testing, and referral (CTR) services in Title X sites. The DFH supported family planning services to women being discharged from the state prison (a third of the discharged women showed up for follow-up care through a Title X site). Many incarcerated women are at risk for unintended pregnancy and poor birth outcomes after their release.

Title X sites continued to collaborate with the state laboratory and HEALTH's STD Program to screen women for Chlamydia. The DFH also continued to support vasectomies for uninsured and under-insured adult men as a way to help prevent unintended pregnancies. The DFH continued to distribute brochures about the Vasectomy Program, in English and Spanish, in FY2004. A third of the men who receive vasectomies through the program are Latino.

The DFH also continued to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment and follow-up services to women in Title X sites. Pregnant women with identified health risks were referred to RIte Care and WIC through FRCs, early prenatal care, and other community-based supports early in pregnancy. Pregnant women can also be referred to the DFH's FOP, who assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care. Women identified with health risks (i.e. smoking, substance abuse, nutritional concerns, mental health needs, etc.) are referred to appropriate follow-up services. Each year, about 3,000 women receive services through the WHSRP. Many of these women struggle with multiple health risks.

The DFH continues to administer the "Keep Your Baby Lead Safe" Program, which refers pregnant women and new parents to the DFH's FOP for lead education and linkage to lead hazard reduction services through local HUD funding.

Ready to Learn Providence (RLP), Newport County CATCH, Washington County CATCH, and Mt. Hope CATCH systems development investments continued to support community assessment and planning activities designed to increase utilization of maternal & child health services, including RIte Care. These investments focus on issues related to "medical homes" and care coordination. Preventing low birth weight babies represents an important part of the DFH's work in this area.

During FY2004, RI PRAMS surveyed all women who delivered low birth weight (including very low birth weight) infants to better understand the mother's experiences and behavior, before, during, and after pregnancy. This information may help provide a better understanding of the factors that may contribute to poor birth outcomes such as low birth weight and very low birth weight //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provides culturally diverse women with access to affordable,				

confidential family planning clinical and educational services through Title X family planning sites.	X			
2. Provides women receiving Title X family planning services with culturally and linguistically appropriate printed informational materials on a variety of preventive health topics.		X		
3. Provides culturally diverse women with free, confidential pregnancy testing and comprehensive health risk assessment and referral services through the Women's Health Screening & Referral Program (WHSRP).	X			
4. Continues to support the WHSRP Steering Commitee to revise and improve the current WHSRP data collection tool.				X
5. Conducted interviews with key community MCH stakeholders and DFH staff to identify new strategies for addessing the health needs of women of reproductive health age.				X
6. Continues to support the "Keep Your Baby Lead Safe" initiative to provide pregnant women and new parents with culturally and linguistically appropriate information about lead poisoning prevention and lead hazard reduction through the FOP.				X
7. Continues to support the Ready to Learn Providence (RLP) and RIAAP CATCH systems development initiatives to increase uilization of MCH services.				X
8. Continues to survey new mothers with low birth weight babies through PRAMS to better understand the mothers' experiences and behavior before, during, and after pregnancy.			X	
9. Is working with the Rhode Island Chapter of the March of Dimes (MOD) and other community partners to statewide develop initiatives to reduce prematurity.				X
10. Held Grand Rounds on prematurity at 3 birthing hospitals and displayed informational boards on prematurity at most of the state's birthing hospitals as a part of "National Prematurity Awareness Day".		X		

b. Current Activities

/2006/ The DFH continues to work to reduce the proportion of all live deliveries with very low birth weight. The DFH continues to support the Title X Family Planning Program. Title X sites continue to provide clients with HIV counseling, testing, and referral (CTR) services. The DFH's Family Planning Program continues to support family planning services to women being discharged from the state prison.

The Family Planning Program and key partners revised and improved the quality of current printed informational materials for family planning clients. The Family Planning Program continues collaborate with the state laboratory and HEALTH's STD Program to screen women for Chlamydia to prevent infertility and promote healthy birth outcomes. The DFH also continues to support vasectomies for uninsured and under-insured adult men and continues to distribute brochures about the program in English and Spanish.

The DFH continues to support the WHSRP. Women identified with health risks through the WHSRP are referred to appropriate follow-up services. The DFH established a WHSRP Steering Committee to revise and improve the existing WHSRP data collection tool.

The DFH has conducted a number of interviews with key MCH stakeholders and DFH staff. The DFH plans to utilize the reminder of FY2005 and FY2006 to identify and develop strategies for addressing the maternal health needs of women. The strategies

developed may help address some of the factors associated with low birth weight and other poor birth outcomes.

The DFH continues to administer KYBLS to educate pregnant women and new parents about lead poisoning and lead hazards. In FY2005, KYBLS is providing home visiting services statewide to any pregnant woman or new parent interested in participating, regardless of home ownership status.

Ready to Learn Providence (RLP) and the DFH's CATCH investments continue to support community assessment and planning activities designed to increase utilization of maternal & child health services. Preventing low birth weight babies represents an important part of the DFH's work in this area.

RI PRAMS continues to survey women who delivered low birth weight infants and premature infants to better understand the mother's experiences and behavior, before, during, and after pregnancy. The DFH has been analyzing data among women who gave birth during 2002 and 2003.

The DFH has been working closely with the RIMOD and other key partners to develop statewide initiatives to reduce prematurity. During 2004 and 2005, Grand Rounds Sessions were held at three hospitals. In addition, informational boards on prematurity were displayed in most of the state's maternity hospitals in response to National Prematurity Awareness Day //2006//.

c. Plan for the Coming Year

/2006/ The DFH will continue to work to reduce the proportion of all live deliveries with very low birth weight. The DFH will continue to support the Title X Family Planning Program. Title X sites will continue to provide clients with HIV CTR services. The DFH will continue to support family planning services to women being discharged from the state prison, collaborate with other HEALTH programs partners to screen women for Chlamydia, support vasectomies for uninsured and under-insured adult men, provide an array of linguistically and culturally appropriate family planning printed informational materials to Title X clients, and support the WHSRP.

The DFH's WHSRP Steering Committee will continue to meet during FY2006 to revise and improve the existing WHSRP data collection tool (i.e. a self-administered survey available in English and in Spanish that is completed by the woman while she is waiting for the results of her pregnancy test). As a part of the process of refining and improving the existing WHSRP data collection survey, the Steering Committee will explore the feasibility of developing a core set of psycho-social questions during FY2006 that can be adapted for use in other settings where women receive health care.

The DFH will continue to explore the feasibility of strengthening its current level of maternal health programming. The DFH will utilize FY2006 continue to identify and develop strategies for addressing the maternal health needs of women. The strategies developed may help address some of the factors associated with low birth weight and other poor birth outcomes.

The DFH will continue to administer KYBLS to educate pregnant women and new parents about lead poisoning and lead hazards. KYBLS will continue to provide home visiting services statewide to any pregnant woman or new parent interested in participating, regardless of home ownership status. Ready To Learn Providence (RLP) and the DFH's CATCH will continue to support community assessment and implementation activities

designed to increase utilization of MCH services.

The DFH will continue to analyze PRAMS data to determine the association of factors, such as access to prenatal care, pregnancy intent, and time during pregnancy, with low birth weight. Lastly, the DFH will continue to work closely with the RI Chapter of the March of Dimes & other partners to develop statewide initiatives to reduce prematurity //2006//.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.1	4	4	4	4
Annual Indicator	8.0	5.3	2.7	2.7	8.0
Numerator	6	4	2	2	6
Denominator	75445	75445	75445	75445	75445
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	4	4	4	4

Notes - 2002

Data reflect calendar year.
Due to small numbers, this performance measure fluctuates from year-to-year. The number of suicide deaths among teens has ranged from 2-6 per year.

Notes - 2003

Data reflect calendar year.
Due to small numbers, this performance measure fluctuates from year-to-year. The number of suicide deaths among teens has ranged from 2-6 per year.

Notes - 2004

2004: Data are provisional and reflect calendar year.
Due to small numbers, this performance measure fluctuates from year-to-year.

a. Last Year's Accomplishments

/2005/ During FY2003, the DFH continued to work to eliminate self-induced, preventable morbidity and mortality among youths ages 15-19 years //2005//. ***/2006/ In FY2004, the 7 DFH supported School-Based Health Centers (SBHCs) continued to provide teenagers with access to no cost comprehensive preventive health and mental health services in racially and ethnically diverse communities. An additional SBHC was added in FY2004 using private foundation funds, which created total number of 8 SBHCs in RI. Teens in need of mental health services were referred for appropriate mental health follow-up evaluation and/or treatment //2006//***.

Consumers who called the DFH's Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals to the Men 2 B and Can We Talk programs. Both of these programs address issues related to adolescent mental health. In FY 2004 the DFH and other partners launched a web site for parents of 9 to 17 year olds. The site included programs, resources, referrals and monthly parenting tips for parents and professionals working with adolescents and pre-adolescents.

The DFH also continued its support of the Men 2B Role Model Support Capacity Program during FY2004. Outreach materials, developed in FY2003, were used to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI. Evaluation data to determine attitude and behavior changes of participants was entered into a program for tracking over time. Results of evaluation data demonstrate effectiveness of Men 2B and role model behavior change. A uniform training guide was developed for Men2 B trainers to build consistent messages and educational materials into the program.

The DFH, in partnership with the RIDE, the Brown University Equity Center, and the RI Principals Association, sponsored a two-day conference on learning & discipline for teachers and administrators. The conference focused on the principles
of social emotional learning, asset building, and the link between safe and nurturing schools and improved school achievement.

The DFH manages the CDC-funded Healthy Schools!/Healthy Kids! initiative. The DFH participated on a state children's mental and behavioral health work group led by RIDE. The group set three priority areas for focus: 1) data/research /evaluation, 2) current state/community/school initiatives, and 3) communications/collaboration. Work group members agreed to incorporate these priorities into the work of their related work groups around SBHCs, safe and supportive schools, school character education, after-school programming, and youth development.

/2005/ Lastly, the DFH's Regional Center for Poison Control & Prevention (RCPCP) reported, and continues to report, data on intentional self-poisonings among teens //2005//. ***/2006/ The RCPCP and its advisory committee continued to monitor and develop strategies to address intentional self-poisonings among youth in RI during FY2004 //2006//***.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Is working with the Stanford University student-run consuling firm Youth Infusion to strenghten statewide capacity to involve youth in the development of programs and initiatives.				X
2. Continues to support the toll-free bilingual Family Health Inforamtion Line which provides callers with "Ten Tips on Parenting Teens" and		X		

referrals to the Men2B and "Can We Talk" programs.				
3. Continues to support a website for parents of 9-17 year-olds and professionals along with other key partners.		X		
4. Continues to support the Men2B Program, which provides training and information to adult men who are parents of or who are working with boys.		X		
5. Continues to participate on a Suicide Prevention Task Force which developed a framework and objectives for Rhode Islanders ages 15 to 24 years.				X
6. Supports 9 School-Based Health Centers (SBHCs) along with other key partners to provide mental health assessment and referral services to culturally diverse teens receiving servcies through the SBHCs.	X			
7. Developed a school emergency planning preparedness, response, and recovery guide, which includes a social and emotional component, along with other key partners.				X
8. Continues to participate on the Child Death Review Team, led by the state Medical Examiner, which reviews all child deaths in the state to determine if they were preventable.			X	
9. Continues to participate on a statewide children's mental health and behavioral group, led by the RI Department of Education (RIDE), as a part of the Healthy Schools!/Healthy Kids! initiative.				X
10. Continues to support the Women's Health Screening & Referral Program (WHSRP) in Title X sites, which refers teens with mental health concerns for appropriate mental health assessment and/or treatment services.	X			

b. Current Activities

/2006/ The DFH is working to reduce suicide deaths among youths aged 15 through 19 by working with numerous partners. The DFH engaged the services of the student-run consulting group Youth Infusion to work with the DFH to strengthen its structural capacity to involve youth in the development of programs and initiatives. Consumers who call the DFH's Family Health Information Line continue to be provided with "Ten Tips on Parenting Teens" and referrals to the Men 2 B Program and "Can We Talk" Program.

A website continues to provide parents of 9-17 year olds and providers with connections to RI programs and resources and includes monthly parenting tips. Promotional posters and mailing cards were developed and are distributed to build consumer utilization. Usability testing and a resulting revision of the site were recently completed. The DFH also continues to support the Men 2B Program. Outreach materials continue to be used to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI. A pilot project at the Men's Adult Correctional Institution is being implemented for men transitioning back to homes and communities.

The DFH is a member of a suicide prevention task force. The task force developed a framework and objectives for Rhode Islanders ages 15 to 24 and now seeks funding to implement some of the strategies. The task force is seeking funding for a violence prevention project called "Stop It". The task force may also consider implementation of an Air Force suicide prevention model on a pilot basis.

The state's 9 SBHCs continue to provide teenagers with access to comprehensive preventive health and mental health services in racially and ethnically diverse communities (an additional SBHC was added in FY2005). Teens in need of mental health

services are referred for appropriate mental health evaluation and/or treatment services. The Women's Health Screening & Referral Program (WHSRP) continue to provide no cost pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns are referred to appropriate mental health assessment and/or treatment services.

The DFH and other partners have developed a School Emergency Planning Preparedness, Response and Recovery Guide. Guides will be distributed to all schools in CD format before the end of the school year. The DFH is also partnering with the RI Critical Incident Stress Management Team to assure that the social and emotional aftermath of an emergency event is addressed.

DFH personnel are participating on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable. Suicides are included in these reviews. Through Healthy Kids!/Healthy Schools!, the DFH continues to participate on a state children's mental and behavioral health work group led by RIDE //2006//.

c. Plan for the Coming Year

/2006/ The DFH will continue to work to eliminate self-induced, preventable morbidity and mortality among youth ages 15-19 years. The state's 9 SBHCs will continue to provide teenagers with access to no cost comprehensive preventive health and mental health services. Teens in need of mental health services will continue to be referred for appropriate follow-up services.

In FY2006, the DFH will continue to implement an on-line resource directory for parents of 9 to 17 year olds. Issues related to the mental health needs of youth are included on the website.

The DFH, will implement strategies recommended by Youth Infusion, which submitted a report with recommendations for engaging youth in FY2005. The website for parents of 9-17 year olds and providers will be promoted as part of a coordinated communications strategy to promote the Men2B program, Can We Talk and Plain Talk in work sites, faith organizations and schools.

The DFH will continue to support the Men 2B Program to prepare men to be confident and effective role models for boys and to builds community capacity to meet the developmental need of boys for safe caring adult relationships.

The DFH will continue to partner with the Division of Disease Prevention and Control on the violence prevention project called "Stop It". The partnership will result in a state report card on risk and protective factors for violence, and a plan to address cross cutting behaviors such as suicide, sexual activity and substance use as well.

The DFH will continue to participate on a suicide prevention task force, which will seek funding to implement strategies for suicide prevention for Rhode Islanders 15 to 24 years old. A Providence-based mental health agency is applying for funding for a suicide prevention project targeting teens in the Training School and in foster care.

The DFH manages the CDC-funded initiative Healthy Schools!/Healthy Kids! (HS/HK). The DFH will continue to participate on a state children's mental and behavioral health work group led by the RI Department of Education (RIDE)during FY2006.

The DFH will continue to participate on the Child Death Review Team The DFH's Regional Center for Poison Control & Prevention (RCPCP) will continue to report data on intentional self-poisonings among teens. The RCPCP and its advisory committee will continue to monitor and develop strategies to address intentional self-poisonings among youth //2006//.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	98	93.8	93.2	93.2	93.5
Annual Indicator	96.3	92.5	96.0	96.1	93.0
Numerator	181	173	214	219	173
Denominator	188	187	223	228	186
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	93.5	94.2	94.2	94.2	94.2

Notes - 2002

Data reflect VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for RI resident births occurring out-of-state.

Notes - 2003

Data reflect VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for RI resident births occurring out-of-state.

Notes - 2004

Data reflect VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for RI resident births occurring out-of-state.

a. Last Year's Accomplishments

/2005/ The DFH continued to work to ensure that high-risk mothers and newborns deliver at appropriate hospital levels. The majority of RI's high-risk pregnancies are delivered at Women & Infants Hospital, which is appropriately staffed and equipped to care for high-risk admissions //2005//. ***/2006/ In FY2004, the DFH continued to support the Women's' Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in 9 of the DFH's 10 federally-funded Title X family planning clinics //2006//***. /2005/ Through the WHSRP, pregnant women with identified health risks were referred to prenatal

care and other community-based supports early in pregnancy. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensured that women are linked to appropriate prenatal care and financial resources (i.e. RIte Care) //2005//.

/2006/ A pediatric development physician working as a consultant for the DFH at the Child Development Center (CDC) continued to provide training to personnel at the NICU at Women & Infants Hospital to help ensure that infants who are delivered in a high-risk facility were referred to the Rhode Island Department of Human Services' (RIDHS's) Early Intervention (EI) Program prior to discharge. In Rhode Island, very low birth weight is considered to be a "single established condition", and low birth weight babies are automatically eligible for EI services. Physician materials developed by the DFH's Communication Unit for the EI Program were provided NICU staff with information on the other risk factors that make a child eligible for EI services as well during FY2004 //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the Women's Health Screening & Referral Program (WHSRP), which comprehensive health risk assessment and referral services (including early prenatal care) to women in Title X sites.	X			
2. Refers pregnant women to culturally diverse Family Outreach Program (FOP) home visitors, who assess women for low birth weight risks and assure that they are linked to prenatal care, through the WHSRP.				X
3. Supports a parent consultant at the Women & Infants Hospital Neonatal Intensive Care Unit (NICU) to help assure that all low birthweigth infants infants are referred to the Early Intervention (EI) Program prior to discharge.				X
4. Continues to distribute EI Program informational materials to NICU staff.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2005/ The DFH continues to work to ensure that high-risk mothers and newborns deliver at appropriate hospital levels. The majority of RI's high-risk pregnancies are delivered at Women

& Infants Hospital, which is appropriately staffed and equipped to care for high-risk admissions //2005//. ***/2006/ In FY2005, the DFH continues to support the Women's' Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in 9 of the DFH's 10 federally-funded Title X family planning clinics //2006//***. /2005/ Through the WHSRP, pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. RIte Care) //2005//.

/2006/A parent consultant in the NICU to provides training to personnel at the NICU at Women & Infants Hospital to help ensure that infants who are delivered in a high-risk facility are referred to the DFH's Early Intervention (EI) Program prior to discharge. The DFH's Newborn Screening Program is working with the RIDHS's EI Program to improve the numbers of low birth weight babies who are referred to the EI Program at the time of hospital discharge. In RI, very low birth weight is considered to be a "single established condition", and low birth weight babies are automatically eligible for EI services. Physician materials developed by the DFH's Communication Unit for the EI Program continue to provide NICU staff with information on the other risk factors that make a child eligible for EI services as well //2006//.

c. Plan for the Coming Year

/2005/ The DFH will continue to work to ensure that high-risk mothers and newborns deliver at appropriate hospital levels. The majority of RI's high-risk pregnancies are delivered at Women & Infants Hospital, which is appropriately staffed and equipped to care for high-risk admissions //2005//. ***/2006/ In FY2006, the DFH will continue to support the Women's' Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 of the DFH's 10 federally-funded Title X family planning clinics //2006//***. /2005/ Through the WHSRP, pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. RIte Care) //2005//.

/2006/ A parent consultant working in the NICU will continue to provide training to personnel at the NICU at Women & Infants Hospital to help ensure that infants who are delivered in a high risk facility are referred to the RIDHS's Early Intervention (EI) Program prior to discharge. The DFH's Newborn Screening Program will continue to work with the EI Program to improve the numbers of low birth weight babies who are referred to the EI Program at the time of hospital discharge //2006//.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care*

beginning in the first trimester.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	92	92.9	91.3	91.5	91.8
Annual Indicator	90.9	91.3	89.6	90.8	90.0
Numerator	10765	10842	10685	10534	10328
Denominator	11844	11869	11919	11604	11479
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90.2	90.4	90.4	90.6	90.6

Notes - 2002

Data reflects Rhode Island resident births occurring in Rhode Island. Birth records with unknown or missing 'month of prenatal care ' are excluded from the denominator.

Notes - 2003

Data reflects Rhode Island resident births occurring in Rhode Island. Birth records with unknown or missing 'month of prenatal care ' are excluded from the denominator.

Notes - 2004

Data reflects Rhode Island resident births occurring in Rhode Island. Birth records with unknown or missing 'month of prenatal care ' are excluded from the denominator.

a. Last Year's Accomplishments

/2005/ The DFH continued to ensure early entry into prenatal care to enhance pregnancy outcomes //2005//. ***/2006/ In FY2004, the DFH continued to support the Women's' Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 of the DFH's 10 Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assessed women for low birth weight risks and ensured that women were linked to appropriate prenatal care and financial resources (i.e. RIte Care). They also stressed the importance of prenatal care.***

In FY2004, the DFH continued to implement the "Keep Your Baby Lead Safe" Program. Pregnant women were referred to the DFH's Family Outreach Program (FOP) for a prenatal visit, including lead education and linkage to lead hazard reduction services through local HUD funding.

The DFH's Family Resource Counselor (FRC) Program continued to support culturally diverse FRCs in 20 community health center sites and 4 hospital outpatient clinics to

identify and enrolled pregnant women into RIte Care, WIC, Food Stamps, the Family Independence Program (FIP), and the childcare Subsidy Program //2006//. /2005/ Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.

The DFH's Communication Unit continued to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answered families' questions and referred them to appropriate community resources, including RIte Care and FRCs. Culturally and linguistically appropriate informational materials were distributed through the Communication Unit's centralized Distribution Center.

The DFH's Newborn Screening Program continued to collect data on the adequacy of prenatal care among pregnant women in RI. This data is utilized to monitor the adequacy of prenatal care in the state //2005//. ***/2006/ In FY2004, a system of integrated data capture for newborn developmental risk assessment and birth certificates was implemented at 6 of 7 maternity hospitals. The DFH's Data & Evaluation Unit analyzes this data for MCH and other reporting purposes.***

In addition, RI PRAMS surveyed women 2-4 months post-delivery in FY2004. The survey includes 6 questions regarding prenatal care, including: time of first prenatal visit, whether they received prenatal care as early in pregnancy as they wanted it, things that kept them from getting prenatal care as early as they wanted, where prenatal care was received, how prenatal care was paid for, and whether specific topics were discussed during the prenatal period //2006//.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the Women's Health Screening & Referral Program (WHSRP), which comprehensive health risk assessment and referral services (including early prenatal care) to women in Title X sites.	X			
2. Refers pregnant women to culturally diverse Family Outreach Program (FOP) home visitors, who assess women for low birth weight risks and assure that they are linked to prenatal care, through the WHSRP.				X
3. Continues to distribute FOP promotional materials to all OB/GYN practices to increase the number of pregnant women who are referred to the FOP.			X	
4. Conducted interviews with key community MCH stakeholders and DFH staff to identify new strategies for addessing the health needs of women of reproductive health age (including prenatal care needs).				X
5. Continues to support the "Keep Your Baby Lead Safe" initiative to provide pregnant women and new parents with culturally and linguistically appropriate information about lead poisoning prevention and lead hazard reduction through the FOP.				X
6. Supports culturally diverse Family Resource Counselors (FRCS) in 20 community health center sites and 4 hospitals to identify and enroll families onto RIte Care.				X
7. Continues to support the toll-free bilingual Family Health Information Line which refers families without health insurance to Rite Care and/or		X		

FRCs for further help with the Rite Care application process.				
8. Continues to collect information on the adequacy of prenatal care among pregnant through the Level I newborn risk screening process.			X	
9. Continues to survey new mothers on the adequacy of prenatal care through PRAMS.			X	
10.				

b. Current Activities

/2005/ The DFH continues to ensure early entry into prenatal care to enhance pregnancy outcomes //2005/. ***/2006/ The DFH continues to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in 9 Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy. Pregnant women with health risks identified through the WHSRP can be referred to the FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources. They also stress the importance of prenatal care. FOP promotional materials are mailed to all OB/GYN practices across the state quarterly. The goal is to increase the number of pregnant women who are referred to the FOP.***

In response to recommendation made by the Regional MCH Office last year, the DFH is utilizing FY2005 to explore the feasibility of strengthening its current level of maternal health programming. To date, the DFH has conducted a number of interviews with key MCH stakeholders, which included a variety of community-based partners in addition to DFH staff. Out of these interviews, several cross cutting themes emerged. The DFH will identify and develop strategies for addressing the needs of women in their reproductive health years.

"Keep Your Baby Lead Safe" (KYBLS) is a free service developed by the DFH's Childhood Lead Poisoning Prevention Program to educate pregnant women and new parents about lead poisoning and lead hazards. In FY2005, KYBLS is providing home visiting services statewide to any pregnant woman or new parent interested in participating, regardless of home ownership status.

The DFH's FRC Program continues to support culturally diverse FRCs in 20 community health center sites and 4 hospital outpatient clinics to identify and enroll pregnant women into RIte Care, WIC, Food Stamps, and the Family Independence Program (FIP), and the Childcare Subsidy Program. Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.

The DFH's Communication Unit continues to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources. Culturally and linguistically appropriate informational materials are distributed through the DFH's centralized Distribution Center.

The DFH's Newborn Screening Program continues to collect data on the adequacy of prenatal care among pregnant women. The DFH analyzes data from Level I screening data, birth files, and PRAMS. Data from PRAMS respondents who delivered during 2002 and 2003 have been analyzed to determine issues related to prenatal care, including barriers to care //2006//.

c. Plan for the Coming Year

//2005/The DFH will work to ensure early entry into prenatal care to enhance pregnancy outcomes //2005// //20006// The DFH continues to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in 9 Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy. Pregnant women with health risks identified through the WHSRP can be referred to the DFH's FOP. FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources. They also stress the importance of prenatal care.

The DFH is utilizing FY2005 to explore the feasibility of strengthening its current level of maternal health programming. During FY2005, the DFH conducted a number of interviews with key MCH stakeholders, which included a variety of community-based partners in addition to DFH staff. Out of these interviews, several cross cutting themes emerged. The DFH will utilize FY2006 to identify and develop strategies for addressing the needs of women. The strategies developed may help address some of the factors associated with late entry into prenatal care.

"Keep Your Baby Lead Safe" (KYBLS) is a free service developed by the DFH's Childhood Lead Poisoning Prevention Program to educate pregnant women and new parents about lead poisoning and lead hazards. In FY2006, KYBLS will continue to provide home visiting services statewide to any pregnant woman or new parent interested in participating, regardless of home ownership status.

The DFH will continue to support culturally diverse FRCs in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care. Like the WHSRP, the FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy. The DFH's Communication Unit will continue to support the toll-free Family Health Information Line and centralized Distribution Center.

The DFH's Newborn Screening Program will collect data on the adequacy of prenatal care among pregnant women in RI through the newborn screening process. FY2005 saw the adoption of an integrated data collection system for this information through an electronic integrated birth certificate/newborn development risk assessment system at 6 maternity hospitals. The new system will be rolled out in the final, and largest, maternity hospital in FY2006.

In addition, the DFH will continue to track rates of prenatal care using multiple sources, including PRAMS. An analysis of prenatal care data was done to determine why rates of first trimester prenatal care have been declining in Westerly over the past several years ***//2006//.***

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of children in child care, aged 19 months or older, who are up-to-date on their immunizations*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	91	91	91	91.2	91.2
Annual Indicator	87.5	89.4	89.9	89.6	90.1
Numerator	12130	12680	12657	11871	12595
Denominator	13863	14183	14083	13250	13977
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	91.3	91.5	91.5	91.5	91.5

Notes - 2002

Data source is the Annual School\Licensed Daycare Immunization Survey. Data presented is for licensed daycares only.

Notes - 2003

2003: Data source is the Annual School\Licensed Daycare Immunization Survey. Data presented is for licensed daycares only.

Notes - 2004

2004: Data source is the Annual School\Licensed Daycare Immunization Survey. Data presented is for licensed daycares only.

a. Last Year's Accomplishments

/2006/ The DFH assessed childcare centers, Head Starts, and kindergartens and provided these sites with ongoing information and TA on current immunization recommendations and regulations. The DFH provided vaccine to all providers, free immunizations to uninsured children, and immunization education to providers and the public. Influenza vaccine (based on supply) was available to any and all children 6 months to 18 years of age.

The DFH piloted an assessment project in two communities to evaluate the immunization status of children receiving childcare through home childcare providers.

The DFH placed an article in the Rhode Island Family Guide on the importance of immunizations. The article included current recommended immunization schedules and addressed common questions parents have about immunizations. Families were referred to the Family Health Information Line and encouraged to request a Health and Safety Record for their child(ren).

The DFH developed a new culturally and linguistically appropriate brochure on immunizations to supplement existing vaccine-specific brochures. The DFH redesigned the Immunization website to include specific sections for families, health care providers, childcare professionals, and school professionals.

The DFH sponsored an event at the Warwick Mall to raise awareness about the importance of immunizations for all ages. Families with young children were referred to primary care providers or free immunization clinics. The DFH hosted an educational conference for childcare directors, nurses, school nurse teachers and Head Start health coordinators to provide up-to-date information on health topics, including

immunizations.

KIDSNET, the DFH's integrated child health information system, collects and tracks immunizations for all children born after 1/1/97 who are seeing a primary care provider (PCPs) in Rhode Island who is participating in KIDSNET. During FY2004, KIDSNET was involved in a variety of efforts to reach children in this age group. Activities included sending families with newborns a Hallmark congratulations card (which included information about the importance of timely immunizations), sending participating PCPS reports of their pediatric patients turning 20 months of age who were behind on their immunizations, and sending autodial messages or mailing "well child reminder" postcards to families as specified intervals. During FY2004, KIDSNET became web-enabled and rolled out a new web application to all participating PCPs and users. This system enhancement allows PCPs and other users to generate lists of their patients on demand, as often as they felt it was necessary for their quality assurance purposes. Additionally, Head Start agencies began using the web application to assess the immunization compliance of their enrollees. Finally, the KIDSNET application began rolling out to School Nurse Teachers, who are responsible for documenting immunizations as a prerequisite for school entry //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to assess the immunization status of children in child care centers, Head Starts, and kindergartens, in accordance with state requirements.			X	
2. Continues to provide ongoing information and training on current immunization recommendations and requirements to child care centers, Head Starts, and kindergartens.		X		
3. Conducted a survey of home child care providers to assess the immunization status of children in their care.			X	
4. Continues to provide vaccine to all providers in Rhode Island.				X
5. Continues to provide uninsured children who are ineligible for RIte Care with no cost immunizations.	X			
6. Continues to utilize KIDSNET to track the immunization status of all children born after 1/1/97.				X
7. Has made a web-based version of KIDSNET availible to pediatric practices, Head Starts, and school nurse teachers.				X
8. Sponsored an annual conference for school nurse teachers, Head Starts, and child care providers to provide up-to-date information on a variety of health topics, including immunizations.			X	
9. Sponsored an annual immunization awareness event at the Warwick Mall.			X	
10. Continues to provide families with children in child care settings with culturally and linguistically apppropriate immunization information through the Healthy Child Care Rhode Island Initiative (HCCRI).		X		

b. Current Activities

/2006/ The DFH is assessing childcare centers, Head Starts, and kindergartens. The DFH provides these sites with ongoing information and TA on current recommendations &

regulations. The DFH distributed surveys to all home childcare providers to assess the immunization status of the children in their care. A total of 1,300 surveys (in English and in Spanish) were mailed, approximately 600 surveys were returned (420 with usable data).

The DFH is providing vaccine to all providers, free immunizations to uninsured children, and immunization education to providers and the public. Influenza vaccine is now available to all children ages 6 months through 18 years. The DFH is increasing awareness of the new policy through health care providers, childcare providers, schools, and the media.

The DFH sponsored its annual immunization awareness event at the Warwick Mall. The DFH hosted its annual conference for childcare directors/nurses, school nurse teachers and Head Start health coordinators to provide up-to-date information on health issues including immunizations.

KIDSNET continues to send parents of newborns a congratulations card with information about the KIDSNET system. KIDSNET continues to be the tracking mechanism to collect immunizations and other public health data for all children born on or after 1/1/97 and is sending reports to participating PCPs regarding their pediatric patients' compliance with immunization by 20 months of age. Auto-dial messages or mailed "well-child reminders" also continue to be sent to families at specified intervals, as a service offered by KIDSNET. With the rollout of the KIDSNET web application, Head Starts and school nurse teachers are using the immunization data to monitor compliance with the immunizations as needed for school entry.

One of the major improvements in the area of immunizations was implemented by KIDSNET in May 2005, when the immunization algorithm was installed. This new feature allows displaying a clear indicator about whether or not the vaccines for a given patient are due or if the series have been completed. All KIDSNET participating providers and users who have access to the immunization screen can now see the message about the vaccines and can offer follow up through the patients' medical home, as appropriate.

The DFH's Healthy Child Care Initiative (HCCRI) continues to provide child care providers with culturally and linguistically appropriate immunization information for families through the Child Care Support Network (CCSN). Information is targeted to both providers and families. HCCRI also continues to provide child providers with training & technical assistance on immunizations. The HEALTH consultant to HCCRI works closely with the DFH's Immunization Program to ensure that child care providers have the most current information available //2006/.

c. Plan for the Coming Year

/2006/ The DFH will continue to conduct assessments at childcare centers, Head Starts, kindergartens, and home childcare providers. The DFH will provide these sites with ongoing information and TA on current immunization recommendations and regulations. The DFH will continue to provide vaccine to all providers, free immunizations to uninsured children, and immunization education to providers and the public.

The DFH will continue to sponsor an event at the Warwick Mall to raise awareness about immunizations for all ages. Families with young children will be referred to PCPs or free immunization clinics for follow-up. The event will be promoted through culturally diverse television interviews, phone banks, and targeted mailings. The DFH will continue to host its annual conference for childcare directors/nurses, school nurse teachers, and Head Start health coordinators to provide up-to-date information on health issues, including

immunizations.

KIDSNET plans to continue to send the congratulations card to all families with newborns two weeks after birth, and to provide PCPs reports of the 20 month old patients who are behind on immunizations, as well as to encourage providers to use the immunization algorithm as a reminder tool to follow up on patients as needed. KIDSNET also plans to make some system enhancements, including programming that will allow the generation of aggregate reports of immunizations due. Additionally, the auto-dialed messages will be removed and instead postcards reminders for well child visits will be mailed to all families at specified intervals.

The DFH will utilize KIDSNET to capture maternal Hepatitis B information. Infants with Hepatitis B positive mothers will be referred to the FOP to facilitate the completion of appropriate immunizations and treatment. Other children who are referred to the FOP will continue to receive information and education regarding the importance of timely immunizations. The WIC Program will assess the provision of DTAP shots as compared to the child's age. Children who are behind on their immunizations will be referred to their PCP or one of the free immunization clinics for follow-up //2006//.

State Performance Measure 2: *Percent of students in schools with health centers who are enrolled in school-based health centers*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	55.0	56.2	56.9	47.2	47.9
Annual Indicator	48.4	56.8	60.5	45.7	45.5
Numerator	3981	4929	5189	4093	4202
Denominator	8228	8677	8575	8959	9235
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	49	49.3	49.5	49.5	49.5

Notes - 2002

The School Based Health Center Program [SBHCP] supports seven school based health centers and their professional/community partners to offer comprehensive preventive care to urban adolescents. SBHCP also provides professional/public education on teen health and mental health needs.

Notes - 2003

2003: There were programming errors in the numerator. Data for FY2003 reflects a correction to the program. Previous years data should be considered estimates. Annual Peformance Objectives have been adjusted to reflect the programming correction.

Notes - 2004

2004 Data are estimated.

a. Last Year's Accomplishments

/2005/ The DFH continued to support 7 School-Based Health Centers (SBHCS) in racially and ethnically diverse urban communities in RI //2005//. ***/2006/An additional SBHC was added in FY2004 with HRSA funding. In FY2004, the DFH continued its efforts to increase enrollment in the 8 SBHCS.***

In FY2004, the SBHC Program and the DFH's Family Planning Program continued to work collaboratively to provide SBHC staff with training and technical assistance about Title X family planning services. SBHC teens in need of confidential birth control services continued to be referred to a Title X site //2006//. /2005/The SBHC Program also worked with the RIte Care plan, Neighborhood Health Plans of RI (NHPRI), to expand the range of preventive health care services being provided to NHPRI members in SBHCS //2005//.

/2006/State funding for SBHCs was reduced this year. Working collaboratively across HEALTH, the DFH was able to secure funds to keep the core support level for each of the DFH's 7 SBHCs at $75,000. Eventually, the DFH hopes to secure state support for all 9 SBHCs and have a mechanism to secure core support for additional SBHCS as they are developed. The National Assembly on School Based Health Care's Annual Convention will be held in Providence on June 16-18.

The DFH's SBHC Program continued to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. The number of schools (including those with a SBHC) and alternative education sites increased to 58 sites, which represents an increase over 49 sites that participated in VBYG in FY2003 //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supports 9 School-Based Health Centers (SBHCs) in racially and ethnically diverse communities to provide comprehensive preventive health services to adolescents, along with other partners.	X			
2. Continues to work to increase enrollment in SBHCs.				X
3. Continues to implement strategies to ensure that teens enrolled in SBHCs are seen at least once for preventive health services during the school year.				X
4. Continued to work with the Title X Family Planning Program to ensure that teens in need of birth control services are referred to a Title X family planning site.				X
5. Is working with Neighborhood Health Plan of RI and other partners to develop a long-term stable SBHC infrastructure in RI.				X
6. Develped and distributed a progress report on the effectiveness of SBHCs in Rhode Island.			X	

7. Continues to collaborate with the Immunization Program's "Vaccinate Before You Graduate" initiative in SBHC (and other school) settings.				X
8.				
9.				
10.				

b. Current Activities

/2005/ The DFH continues to support 7 School Based Health Centers (SBHCS) in racially and ethnically diverse urban communities in Rhode IslandI//2005//. ***//2006//There are two additional SBHCS; one is funded through HRSA and the other (which was added in FY2005) has a combination of private and community organization support. In FY2005, the DFH continued its efforts to increase enrollment in the 9 SBHCS //2006//***. /2005/Currently, staff are working on an evaluation model linking SBHC data for key health conditions with time lost from school. Staff work with community health center and school staff to address technical issues to facilitate the evaluation process//2005//. ***/2006/The SBHCs are developing and implementing strategies to ensure that teens that have parental permission to be seen at the SBHC are seen at least once during the school year with an emphasis on preventive health care. The DFH's SBHC Program is compiling a revised risk questionnaire to be administered to students at preventive health visits.***

In FY2005, the SBHC Program and the DFH's Family Planning Program continued to work collaboratively to provide SBHC staff with training and technical assistance about Title X family planning services. SBHC teens in need of confidential birth control services continue to be referred to a Title X site. SBHC Program staff is working with staff from Neighborhood Health Plans of Rhode Island (NHPRI), the state's largest RIte Care insurer, to develop a business plan to provide a long-term stable infrastructure for SBHCS //2006//.

/2005/ In FY2002, The DFH's Communication Unit, in collaboration with the SBHC Program developed and disseminated a report on the effectiveness of SBHCS in RI. The purpose of the report was to gather community support for an action plan to sustain funding for and expand the number of SBHCS in RI. The report was disseminated to state policy-makers, including the legislature, and about 1,000 other stakeholders throughout the state. In FY2003, the DFH developed and distributed a progress report on the recommendations contained in the first report. The second report was distributed to about 500 stakeholders throughout the state //2005//.

/2006/ The DFH's SBHC Program continues to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. Fifty-four schools (including SBHCs) and alternative sites are currently participating in VBYG //2006//.

c. Plan for the Coming Year

/2005/ Increasing the number of adolescents enrolled in School-Based Health Centers (SBHCs) helps ensure their access to health services and ultimately improves their health, safety, and well-being. The DFH will continue to support SBHCS in racially and ethnically diverse urban communities in RI. The SBHC Program and the Communication Unit will utilize FY2005 to continue with efforts to further increase SBHC utilization //2005//. ***/2006/In FY2004, an 8th SBHC was added to the states' SBHC network and in FY2005 another SBHC was added. DFH SBHC Program staff will continue to develop and implement a business plan to provide a long-term stable fiscal infrastructure to support 9 SBHCS that includes state core funding in FY2006 //2006//***. /2005/Several more schools want to start SBHCs, but funds are lacking to support further expansions. In addition, the SBHC Program will work to address

SBHC capacity to address the mental health needs of students in SBHCs. Adequate capacity to address the mental health needs of adolescent's remains a statewide concern.

Currently staff are working on an evaluation model linking school based health data for key health conditions with time lost from school //2005//. ***/2006/ In FY2005, the evaluation plan will be fully implemented //2006//***. The SBHCS will supply the DFH with a data disk that can be matched with school-based data. Data will be submitted monthly to ensure accuracy. The DFH will work with the SBHCs to ensure that data is reported in a timely and consistent fashion between and within each SBHC. The SBHCs will implement a risk behavior questionnaire to each preventive health visit. Information will be aggregated on-site and be used to inform the development of health promotion programs//2005//.

/2006/DFH staff will continue to work with the SBHCs to ensure that students have access to reproductive health services within the framework of existing statutes. In FY2006, the SBHC Program and the DFH's Family Planning Program will continue to work collaboratively to provide SBHC staff with training and technical assistance about Title X family planning services//2006//. SBHC teens in need of confidential birth control services will continue to be referred to a Title X site. The SBHC Program will continue to work with the RIte Care plan, Neighborhood Health Plans of RI (NHPRI), to expand the range of preventive health care services being provided to NHPRI members in SBHCS //2005//.

/2006/ The DFH's SBHC Program will continue to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. VBYG will continue to be offered to any Rhode Island high school. In FY2006, the new meningococcal conjugate vaccine will be offered to both 9th and 12th graders //2006//.

State Performance Measure 3: *The proportion of pregnant women who receive an alpha-fetoprotein (AFP) test*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	51	51	51.5	51.8	52
Annual Indicator	47.4	48.7	50.7	54.3	58.3
Numerator	8375	8642	9166	10151	10150
Denominator	17674	17763	18076	18705	17408
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52	52.2	52.2	52.2	52.2

Notes - 2002

ACOG recommends multiple marker screenings in pregnancy be done. As a result of the

ACOG recommendation, marker screenings are uniformly offered and covered by health insurance plans. AFP screening tests, along with other marker screenings, are recommended for women with gestational ages between 15 weeks through 22 weeks and 6 days.

The numerator is the number of pregnant women who received AFP tests at the regional perinatal center's (Women and Infants Hospital) Prenatal Diagnostic Center. It does not include pregnant women who may have received tests elsewhere. Currently, 68% of all births occur at the regional perinatal center.
The denominator reflect resident data which is provisional and maybe updated.
Annual Performance Objectives were lowered for 1999-2005, since recent trend indicates that more women are being screened elsewhere.

Notes - 2003

2003: ACOG recommends multiple marker screenings in pregnancy be done. As a result of the ACOG recommendation, marker screenings are uniformly offered and covered by health insurance plans. AFP screening tests, along with other marker screenings, are recommended for women with gestational ages between 15 weeks through 22 weeks and 6 days.

The numerator is the number of pregnant women who received AFP tests at the regional perinatal center's (Women and Infants Hospital) Prenatal Diagnostic Center. It does not include pregnant women who may have received tests elsewhere. Currently, 68% of all births occur at the regional perinatal center.
The denominator reflect resident data which is provisional and maybe updated.

Notes - 2004

ACOG recommends multiple marker screenings in pregnancy be done. As a result of the ACOG recommendation, marker screenings are uniformly offered and covered by health insurance plans. AFP screening tests, along with other marker screenings, are recommended for women with gestational ages between 15 weeks through 22 weeks and 6 days.

The numerator is the number of pregnant women who received AFP tests at the regional perinatal center's (Women and Infants Hospital) Prenatal Diagnostic Center. It does not include pregnant women who may have received tests elsewhere. Currently, 68% of all births occur at the regional perinatal center.
The denominator reflect resident data which is provisional and maybe updated.

a. Last Year's Accomplishments

/2006/ Access to genetics services, including testing and counseling, is key in reducing the occurrence of birth defects and poor birth outcomes. AFP screening is one measure of genetics service access. The DFH's WHSRP provided no cost pregnancy testing and comprehensive health risk assessment to women, including teens, receiving services in Title X clinics. Pregnant women participating in the WHSRP who report that they have a family member with history of birth defects or developmental delay in their family or their partner's family were referred for genetics counseling and testing services, including AFP screening. Pregnant and non-pregnant women received folic acid information through culturally and linguistically appropriate materials produced by the March of Dimes (MOD).

Multi-vitamins with folic acid were provided to pregnant and non-pregnant women through the WHSRP during FY2004. Non-pregnant women received a year's supply. Pregnant women were given a 3-month supply to hold them over until they had their first prenatal visit and were given a prescription for prenatal vitamins. The MOD provided the vitamins through a MOD Folic Acid Grant and a vitamin price-fixing settlement negotiated through the RI Attorney General's Office. All local WIC agencies continued to provide culturally and linguistically appropriate folic acid informational materials and education to post-partum WIC participants during this period as well.

The DFH's Newborn Screening Program collaborated with the Rhode Island Public Health Association (RIPHA) to develop of a new brochure about the importance of genetics testing, which targets low literacy populations. The DFH helped distribute this new brochure throughout the state. In December of 2004, the brochure was distributed at the annual NERGG conference.

The DFH repeated a study during FY2003 for the period 1998-2000 to compare rates of open neural tube defects before and after the fortification of grains with folic acid. The earlier study, which was done for the period 1991-1997, provided a baseline for open neural tube defects prior to grain fortification. Data from the study were analyzed by the DFH and show that the rate of neural tube defects in Rhode Island decreased by 13% from 10.5 per 10,000 population during 1991-1997 (prior to grain fortification) to 9.4 per 10,000 population during 1998-2000. The DFH continues to review medical records of newborns with birth defects to determine any tests, services, or referrals they received, or the mother received, during the prenatal period. The DFH also continues to work with RI Hospital to obtain data on children with birth defects //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the Women's Health Screening & Referral Program (WHSRP) which refers newly identified pregnant women in Title X sites to genetics counseling and testing services, as appropriate.	X			
2. Provides women receiving pregnancy testing through the WHSRP with culturally and linguistically appropriate information and education about the importance of folic acid consumption.		X		
3. Continues to provide WIC enrollees with culturally and linguistically appropriate information and education about the importance of folic acid consumption.		X		
4. Refers pregnant women participating in the WHSRP to (FOP) home visitors who assess women for at risk pregnancies and refer them for genetics counseling and testing services, as appropriate.				X
5. Continues to work with the RI Public Health Association (RIPHA) to distrubute a new genetics brochure targeting low-literacy populations.		X		
6. Continues to work with Woman & Infants Hospital to obtain prenatal testing and diagnostic data to include in the Birth Defects Surveillance database.			X	
7. Continues to abstract medical records to determine the prenatal tests, genetics counseling, referrals, and other services that were offered to women who deleivered a baby with a birth defect.				X
8.				
9.				
10.				

b. Current Activities

/2005/ The DFH's WHSRP provides no cost pregnancy testing and comprehensive health risk

assessment to women, including teens, receiving services in 9 Title X clinics. Pregnant women who report that they have a family member with history of birth defects or developmental delay in their family or their partner's family are referred for genetics counseling and testing services, including AFP screening //2005//.

/2006/ Pregnant and non-pregnant women receiving services through the DFH's WHSRP and Title X Family Planning Program continue to receive folic acid information through culturally and linguistically appropriate materials produced by the March of Dimes (MOD). Pregnant women continue to be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. RIte Care, Food Stamps, Family Independence Program, etc.). Home visitors also provide support and education to pregnant women about AFP testing, as appropriate. In addition, all local WIC agencies continue to receive folic acid informational materials produced by the MOD to distribute to post-partum WIC participants during FY2005.

The DFH continued to work collaboratively with the RI Public Health Association to distribute a new genetics brochure targeting low literacy populations. The goal of the brochure is to increase awareness of genetics testing and counseling services and to help consumers understand when genetics testing is of value. It is being distributed to families through OB/GYNs, pediatricians, family practice doctors, community health centers and community action programs.

The DFH's Birth Defects Program continues to work with Woman & Infants Hospital and the Fetal Treatment Program to obtain prenatal testing and diagnosis data. Representatives from these clinics and programs are on the Birth Defects Advisory Council. The DFH's Birth Defects Program also continues to abstract medical records to determine the prenatal tests, genetics counseling, referrals, and other services that were offered to women who delivered a baby with a birth defect //2006//.

c. Plan for the Coming Year

/2005/ Access to genetics services, including testing and counseling, is key in reducing the occurrence of birth defects and poor birth outcomes. AFP screening is one measure of genetics service access. The DFH's WHSRP will continue to provide no cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in Title X clinics.

Pregnant women who report that they have a family member with history of birth defects or developmental delay in their family or their partner's family will continue to be referred for genetics counseling and testing services, including AFP screening. Pregnant and non-pregnant women will continue to receive folic acid information through culturally and linguistically appropriate materials produced by the March of Dimes (MOD) //2005//.

/2006/ Pregnant women receiving services through the WHSRP will continue to be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources (i.e. RIte Care, Food Stamps, Family Independence Program, etc.) //2006//. /2005/ Home visitors will also continue to provide support and education to pregnant women about AFP testing, as appropriate //2005//. ***/2006/ In addition, all local WIC agencies will continue to receive folic acid informational materials produced by the March of Dimes (MOD) to distribute to post-partum WIC participants during FY2006.***

The DFH will continue to collaborate with the Rhode Island Public Health Association to distribute the brochure highlighting the importance of genetics testing throughout the

state. The funder of the brochure, Pfizer, is also distributing the brochure and Regional Newborn Screening Group is considering distribution in other states.

The DFH's Birth Defects Program will continue to review medical records of newborns with birth defects to determine any tests, services, or referrals they received, or the mother received, during the prenatal period. The program will also continue to work with Women & Infants Prenatal Diagnosis Center and RI Hospital's Genetics Counseling Center and Child Development Center to obtain prenatal diagnosis and other testing and service data //2006//.

State Performance Measure 4: *Percent of pregnant women in at-risk population subgroups who received prenatal care beginning in the first trimester. (Data presented are for African Americans only)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90.0	90.7	85.5	85.5	85.7
Annual Indicator	86.1	84.6	79.8	82.1	82.3
Numerator	920	887	828	844	817
Denominator	1069	1049	1037	1028	993
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85.9	86	86	86	86

Notes - 2002

Out-of-state resident births for 2002 are not available.
"Population subgroups" are defined as: African American, Asian, Native American, Hispanic women and/or those residing in the five core cities. Data for all population subgroups is generated, analyzed and reported on. Due to space only data on African American women is reported in this State Performance Measure.

Data for this performance measure reflect the proportion of African American women only who received prenatal care in the first trimester. Data excludes those pregnant African American women for whom month prenatal care began was unknown.

Notes - 2003

Out-of-state resident births for 2003 are not available.
"Population subgroups" are defined as: African American, Asian, Native American, Hispanic women and/or those residing in the five core cities. Data for all population subgroups is generated, analyzed and reported on. Due to space only data on African American women is reported in this State Performance Measure.

Data for this performance measure reflect the proportion of African American women only who received prenatal care in the first trimester. Data excludes those pregnant African American women for whom month prenatal care began was unknown.

Notes - 2004

Out-of-state resident births for 2004 are not available.
"Population subgroups" are defined as: African American, Asian, Native American, Hispanic women and/or those residing in the five core cities. Data for all population subgroups is generated, analyzed and reported on. Due to space only data on African American women is reported in this State Performance Measure.

Data for this performance measure reflect the proportion of African American women only who received prenatal care in the first trimester. Data excludes those pregnant African American women for whom month prenatal care began was unknown.

a. Last Year's Accomplishments

/2006/ Rhode Island enjoys high rates of early entry into prenatal care. During FY2004, The DFH continued to work to ensure early entry into prenatal care to enhance pregnancy outcomes through a variety of strategies. The DFH continued to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy.

Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources. They also stress the importance of prenatal care and provide women with culturally and linguistically appropriate materials on a wide variety of topics, including prenatal care.

The DFH continued to administer the "Keep your Baby Lead Safe" Program, to engage pregnant women in an awareness program about the dangers of lead through home visits provided by the Family Outreach Program (FOP), and to engage them in lead hazard reduction efforts to ensure their homes are lead safe for the newborn. The DFH continued to support culturally diverse Family Resource Counselors (FRCs) in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care. The FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.

The DFH's Communication Unit continued to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including RIte Care and FRCs. Culturally and linguistically appropriate informational materials are distributed through the DFH's centralized Distribution Center.

The DFH's Level I risk screening process continued to collect data on the adequacy of prenatal care among pregnant women in RI by race/ethnicity and socio-economic status. This data is utilized to monitor the adequacy of prenatal care in the state. RI PRAMS, which includes several questions regarding prenatal care, continued to survey recent mothers in FY2004 //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the Women's Health Screening & Referral Program (WHSRP), which provides comprehensive health risk assessment and referral services (including early prenatal care) to women in Title X sites.	X			
2. Refers pregnant women to culturally diverse Family Outreach Program (FOP) home visitors, who assess women for low birth weight risks and assure that they are linked to prenatal care, through the WHSRP.				X
3. Continues to distribute FOP promotional materials to all OB/GYN practices to increase the number of pregnant women who are referred to the FOP.			X	
4. Conducted interviews with key community MCH stakeholders and DFH staff to identify new strategies for addessing the health needs of women of reproductive health age (including prenatal care needs).				X
5. Continues to support the Keep "Your Baby Lead Safe" initiative which provides pregnant women and new parents with culturally and linguistically appropriate information about lead poisoning prevention and lead hazard reduction through the FOP.				X
6. Supports culturally diverse Family Resource Counselors (FRCS) in 20 community health center sites and 4 hospitals to identify and enroll families onto RIte Care.				X
7. Continues to support the toll-free bilingual Family Health Information Line which refers families without health insurance to Rite Care and/or FRCs for further help with the RIte Care application process.		X		
8. Continues to collect information on the adequacy of prenatal care among pregnant women through the Level I newborn risk screening process.			X	
9. Continues to survey new mothers on the adequacy of prenatal care through PRAMS.			X	
10.				

b. Current Activities

/2006/ The DFH continues to work to ensure early entry into prenatal care to enhance pregnancy outcomes through a variety of strategies. The DFH continues to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in Title X family planning sites. Through the WHSRP, pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy.

Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources. They also provide women with culturally and linguistically appropriate materials on a wide variety of topics, including those that focus on the importance of prenatal care. FOP promotional materials (brochures and posters) are mailed to all OB/GYN practices across the state quarterly. The goal is to increase the number of pregnant women who are referred to the FOP.

"Keep Your Baby Lead Safe" (KYBLS) is a free service developed by the DFH's Childhood Lead Poisoning Prevention Program to educate pregnant women and new parents about lead poisoning and lead hazards. KYBLS provides home visiting services statewide to any pregnant woman or new parent interested in participating, regardless of home ownership status. A new KYBLS brochure and educational campaign was launched in early January of 2005 and OB/GYN providers were engaged in the referral process.

The DFH supports culturally diverse Family Resource Counselors (FRCs) in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care, which provides pregnant women with access to comprehensive prenatal care. Uninsured pregnant women applying for WIC services continue to be referred to FRCs for assistance with enrollment into RIte Care. The FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.

The DFH's Communication Unit continues to support the toll-free Family Health Information Line, which is a statewide resource for all families. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including RIte Care and FRCs. Culturally and linguistically appropriate informational materials is distributed through the DFH's centralized Distribution Center.

The DFH's Level I risk screening process continues to collect data on the adequacy of prenatal care among women. These data, along with birth certificate data, are analyzed by the DFH. The DFH is analyzing PRAMS data (from respondents who gave birth in 2002 and 2003) to determine the maternal characteristics and issues related to access to prenatal care //2006//.

c. Plan for the Coming Year

/2006/ During FY2006, The DFH will continue to work to ensure early entry into prenatal care to enhance pregnancy outcomes through a variety of strategies. The DFH will continue to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment and follow-up services to women receiving pregnancy testing services in Title X family planning clinics. Pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy.

Pregnant women with health risks identified through the WHSRP can be referred to the DFH's Family Outreach Program (FOP). FOP home visitors assess women for low birth weight risks and ensure that women are linked to appropriate prenatal care and financial resources. They also provide women with culturally and linguistically appropriate materials on a wide variety of topics, including those that focus on the importance of prenatal care. FOP promotional materials (brochures and posters) are mailed to all OB/GYN practices across the state quarterly. The goal is to increase the number of pregnant women who are referred to the FOP in FY2006.

"Keep Your Baby Lead Safe" (KYBLS) continues to educate pregnant women and new parents about lead poisoning and lead hazards. In FY2006, KYBLS will continue to provide home visiting services statewide to any pregnant woman or new parent interested in participating, regardless of home ownership status.

The DFH will continue to support FRCs in 20 community health center sites and 4 outpatient hospital clinics to identify and enroll eligible families into RIte Care, WIC,

Food Stamps, the Family Independence Program (FIP), and the Childcare Subsidy Program. The FRC Program ensures that pregnant women can access prenatal care and other support services early in pregnancy.

The DFH's Communication Unit will continue to support the toll-free Family Health Information Line, which is a statewide resource for all families. Bi-lingual information specialists answer families' questions and refer them to appropriate community resources, including RIte Care and FRCs. Culturally and linguistically appropriate informational materials will continue to be distributed through the DFH's centralized Distribution Center.

The DFH's Level I risk screening process will continue to collect data on the adequacy of prenatal care among pregnant women in RI by race/ethnicity and socio-economic status through the newborn screening process. The DFH will continue to conduct PRAMS and analyze existing data to determine maternal characteristics, including race/ethnicity, and other factors associated with prenatal care //2006//.

State Performance Measure 5: *Percent of children less than 6 years of age in at-risk population subgroups with lead levels greater than or equal to 10ug/dL (data presented will reflect lead levels in Core Cities)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14.5	13.5	13	12.5	11
Annual Indicator	14.7	13.2	11.6	8.2	7.6
Numerator	2018	2022	1750	1340	1226
Denominator	13707	15363	15096	16334	16225
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10.5	10.2	9	8.7	8.5

Notes - 2002

From 1998 and on, this State Performance Measure reflects lead levels greater than or equal to 10ug/dl among children residing in Rhode Island's core cities. Prior to 1998, data reflects lead levels greater than or equal to 10ug/dl among non-white children state wide.

Notes - 2003

2003: From 1998 and on, this State Performance Measure reflects lead levels greater than or equal to 10ug/dl among children residing in Rhode Island's core cities. Prior to 1998, data reflects lead levels greater than or equal to 10ug/dl among non-white children state wide.

Notes - 2004

From 1998 and on, this State Performance Measure reflects lead levels greater than or equal to 10ug/dl among children residing in Rhode Island's core cities. Prior to 1998, data reflects lead levels greater than or equal to 10ug/dl among non-white children state wide.

a. Last Year's Accomplishments

/2006/ The proportion of children with blood lead levels greater than or equal to 10 mcg/dl decreased from 6.1% in CY2000 to 3.7% in CY2004. The percentage of children entering kindergarten who ever had an elevated blood lead level of 10 mcg/dl or more, continued to decline as well. In FY2004, 10.8% of the children who will be entering kindergarten had an elevated blood lead level at some point in their lives, compared to 12.3% in FY2003.

The four lead centers that provide case management services to all significantly lead poisoned children have received referrals for all cases that meet these criteria. In FY2004, the lead centers (certified by the RIDHS) received a total of 172 referrals for significantly lead poisoned children, as well as 194 children with first time venous blood lead levels between 15 and 19 mcg/dl. About 78% of the families with a significantly lead poisoned child have accepted case management services through the lead centers.

The DFH continued to develop a quality assurance strategy with the new tool implemented in June of 2003, the "LESS" database, which facilitates the collection, tracking an devaluation of screening, case management, and environmental data and allows easy generation of a number of reports to measure screening rates. The DFH supported two hospital-based clinics to screen uninsured and underinsured children under age six for lead poisoning. Lead safety remained a part of the DFH's FOP standard home assessment protocols for all families who receive home visiting services, including those with newborns.

The DFH continued to distribute all lead educational materials through the DFH's centralized distribution center and to provide information to families and providers who contact the DFH's Family Health Information Line. The DFH utilized parent consultants to educate providers about lead issues and to staff community health fairs and workshops on lead in culturally diverse neighborhoods throughout the state.

The DFH conducted lead poisoning awareness and prevention activities on an ongoing basis, with a new emphasis on reaching pregnant women. DFH staff visited OB/GYNs and gave them a package of informational materials on lead poisoning prevention during pregnancy (which included culturally appropriate informational brochures for their clients in English and in Spanish).

WIC continued to monitor lead screening in WIC enrolled children with lead levels at or above 10 mcg/dl and continue to provide them with nutrition counseling and education and nutritious foods. The DFH's Immunization Program continued to include lead screening questions in the annual Immunization School Survey sent to schools and childcare centers.

The DFH continued to survey mothers through the PRAMS survey. Data from the survey show that 97.2% of respondents who gave birth during 2002 believed that parents could prevent childhood lead poisoning //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Continues to support two outpatient hospital-based clinics to provide screening to uninsured children under age six for lead poisoning.	X			
2. Continues to support, along with the RI Department of Human Services, (RIDHS), 4 certified lead centers to provide case management to significantly lead poisoned children and children with 1rst time venous lead levels between 15 & 19 mcg/dl.				X
3. Continues to collaborate with HEALTH's Office of Environmental Health to provide significantly lead poisoned children under age six with comprehensive environmental lead inspections.				X
4. Continues to provide children under age six with 1rst time venous lead levels between 15 & 19 mcg/dl with referrals for case management services.				X
5. Utilizes KIDSNET to send post cards to families of all 12-month old children reminding them to schedule a lead screening test for their child at the 1-year well child visit.				X
6. Made a web-based version of KIDSNET available to pediatric practices who can use it to run reports to identify their unscreened patients.				X
7. Continued to conduct lead poisoning awareness and prevention activities as a part of an annual statewide "Lead Poisoning Prevention Month".			X	
8. Supports parent consultants to educate providers about lead issues and to staff community health fairs and workshops on lead throughout the state.				X
9. Continues to monitor lead screening in WIC-enrolled children with lead levels at or above 10 mcg/dl and provide their families with counseling and education about nutritious foods to help bring down their lead levels.		X		
10. Continues to survey new mothers about lead topics through PRAMS.			X	

b. Current Activities

/2006/ The DFH continues to support two hospital-based clinics to screen uninsured and underinsured children under age six for lead poisoning. Four certified lead centers continue to provide case management services to significantly lead poisoned children, as well as those with first time venous lead levels between 15 and 19 mcg/dl. While significantly lead poisoned children receive a comprehensive environmental lead inspection through HEALTH certified private inspectors, the group of children with blood lead levels between 15 and 19 mcg/dl are offered case management and referrals to other social services. Lead safety also remains a part of the FOP's standard assessment protocol for all families who receive home visiting services, including those with newborns.

KIDSNET continues to mail post cards to families of all 12-month old children reminding them to schedule a lead screening visit for their child at the one-year well child visit. With the availability of the new KIDSNET web application, providers participating in KIDSNET are now able to generate on-demand reports of their patients who remain unscreened for lead as often as they need to, from their own offices. These lists can be used as a quality assurance tool for providers to follow-up with patients in need of lead screening. Since the implementation of the KIDSNET web application, at least 80% of the providers who have access to the web application have generated these reports in their offices at least once, according to reports that are monitored monthly by KIDSNET.

The DFH continued to conduct childhood lead poisoning awareness and prevention activities. For the 7th consecutive year, RI celebrated May as "Lead Poisoning Prevention Month" and awarded community partners and pediatricians for continuing efforts in lead poisoning prevention at a special event. The DFH also continues to utilize parent consultants to educate providers about lead issues and to staff community health fairs and workshops on lead throughout the state. WIC continues to monitor lead screening in WIC-enrolled children with lead levels at or above 10 ug/dl and to provide them with nutrition counseling and education and nutritious foods. The DFH's Immunization Program continues to include questions about lead screening on the School Immunization Annual Survey that is completed by schools and childcare centers throughout the state.

The DFH continues to survey recent mothers through PRAMS. The DFH developed two new questions related to lead for the newest version of PRAMS (Phase V). The first question asks whether the house the respondent lives in was built after 1977. If they say no, the respondent is asked what they are currently doing to protect their family from lead poisoning (e.g. washing windows, taping chipped paint, etc.). The Phase V questionnaire containing these new questions was implemented with women who gave birth in 2004 //2006//.

c. Plan for the Coming Year

/2006/ The DFH will continue to support two hospital-based clinics to screen uninsured and under-insured children for lead poisoning. The DFH will refer significantly lead poisoned children for comprehensive home inspections through HEALTH's Environmental Lead Program and for case management services through one of four lead centers certified by the RIDHS in the state. Children with first time lead levels of 15-19 mcg/dl will receive a referral to a lead center for case management.

The families of children with lead levels 10-14 mcg/dl will receive culturally and linguistically appropriate printed lead educational materials. Lead safety will remain a part of the Family Outreach Program's (FOP's) standard home assessment protocols for all families who receive home visiting services, including those with newborns. The DFH's "Keep Your Baby Lead Safe" initiative will continue to provide pregnant women with lead and prenatal education through FOP home visitors and, if eligible, referrals to the weatherization program and lead hazard reduction resources.

Reminders and contacts to families to ensure lead screening will continue to occur through KIDSNET. KIDSNET will continue to mail post cards to the families of 12-month old children as a reminder to schedule lead screening at the one-year well child visit. Letters to parents of all 18-month old children who are not screened will continue to be sent on a monthly basis. With the newly implemented web-based application, KIDSNET will continue to be used as a mechanism for pediatric practices to generate their own reports of unscreened children as a quality assurance tool. Head Start agencies in the state will continue to use KIDSNET to verify lead screening.

The DFH will continued to conduct lead poisoning awareness and prevention activities, with a primary emphasis on pregnant women, on an ongoing basis. For the 8th consecutive year, RI will continue to celebrate May as "Lead Poisoning Prevention Month" with statewide outreach and education efforts. The DFH will continue to utilize parent consultants to conduct workshops and capitalize efforts on quality assurance and education about the new Lead Hazard Mitigation Law, especially to property owners and tenants.

WIC will monitor lead screening in WIC-enrolled children with lead levels at or above 10

mcg/dl and provide them with nutrition counseling and education and nutritious foods. The Immunization Program will include questions about lead screening on immunization forms utilized by schools and childcare centers as a prerequisite for entry.

The DFH's Data & Evaluation Unit will continue to conduct RI PRAMS during FY2006 and analyze data from the new question that was added in the Phase V version //2006//.

State Performance Measure 6: *The percent of 9th graders who are expected to graduate from high school.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	82	82	82	82.2	82.5
Annual Indicator	81.8	81.1	84.0	81.0	83.0
Numerator	8539	8648	9799	9449	9995
Denominator	10434	10660	11665	11665	12042
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82.5	82	82	82	82

Notes - 2002

High School Graduation Rate: percentage of ninth grade class expected to graduate, based on the existing drop-out incidence of 9th, 10th, 11th and 12th grade students. Data reflect school year.

Notes - 2003

High School Graduation Rate: percentage of ninth grade class expected to graduate, based on the existing drop-out incidence of 9th, 10th, 11th and 12th grade students. Data reflect school year and are for public schools.

Notes - 2004

High School Graduation Rate: percentage of ninth grade class expected to graduate, based on the existing drop-out incidence of 9th, 10th, 11th and 12th grade students. Data reflect school year and are for public schools.

a. Last Year's Accomplishments

/2006/ The DFH continued to work to increase the percentage of 9th graders who are expected to graduate from high school. The state's 8 SBHCs (the 8th was added in FY2004) continued their efforts to increase enrollment in SBHC sites.

Unintended pregnancy can interfere with educational goals. During FY2004, The DFH continued to support 10 Title X family planning clinics to provide confidential and low

cost reproductive health services to teens. In addition, the DFH's WHSRP continued to provide no cost pregnancy testing and comprehensive health risk assessment and follow-up services to teens in Title X clinics. Teens with a negative pregnancy test were provided with family planning services on-site and teens with a positive pregnancy test were referred to the RIDHS's Adolescent Self-Sufficiency Program, which provides case management and other supportive services to pregnant and parenting teens.

Consumers who called the DFH's Family Health Information Line were provided with "Ten Tips on Parenting Teens" and referrals to the Men 2 B Program. In FY2004, the DFH and other key partners launched a web site for parents of nine to 17 year olds and providers. The site included programs, resources, referrals and monthly parenting tips for parents and professionals working with adolescents and pre-adolescents.

The DFH also continued to support of the Men 2B Program. Outreach materials, developed in FY2003, were used to increase Men 2B enrollment in worksites, schools, and faith-based organizations in RI. A uniform training guide was developed for Men2 B trainers to build consistent messages and educational materials into the program. A role model handbook was developed as an educational reference tool for participating role models.

Healthy Schools!/Healthy Kids!, worked with other key partners to develop data briefs based on Youth Risk Behavior Survey (YRBS) and SALT data. This publication is the first in which the DFH plans to be a series of briefs to help school leadership utilize data to improve schools.

The DFH, in partnership with the RIDE, the Brown University Equity Center, and the RI Principals Association, sponsored a two-day conference on learning & discipline for teachers and administrators. The conference focused on the principles of social emotional learning, asset building, and the link between safe and nurturing schools and improved school achievement.

The DFH's SBHC Program continued to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. The number of schools (including those with a SBHC) and alternative education sites increased to 58 sites, which represents an increase over 49 sites that participated in VBYG in FY2003 //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to work to increase enrollment in 9 School Based Health Centers (SBHCS), along with other partners.				X
2. Continues to support confidential family planning services for adolescents through Title X family planning sites.	X			
3. Continues to support the Women's Health Screening & Referral Program (WHSRP) which provides no cost pregnancy testing and comprehensive health risk assessment & referral services to teens in Title X sites.	X			
4. Participates on a statewide Teen Pregnancy Prevention Coalition,				

which is working to address the need for access to health care, primary and secondary pregnancy prevention strategies, and comprehensive sexuality education in schools.				X
5. Engaged the services of a Stanford University student-run consulting firm Youth Infusion to strengthen statewide capacity to involve youth in the development of programs.				X
6. Continues to support a website for parents of 9-17 year olds and professionals.		X		
7. Continues to support the Men2B Program, which provides training and information to adult men who are the parents of and/or who are working with boys.		X		
8. Produced and distributed issues briefs around a variety of topics utilizing YRBS and SALT survey data through Healthy Schools!/Healthy Kids!.			X	
9. Developed, along with other partners, a school emergency planning preparedness, response, and recovery guide which includes a social and emotional component.				X
10. Continues to administer the "Vaccinate Before You Graduate" initiative in schools.				X

b. Current Activities

/2006/ The state's 9 SBHCs (the 9th was added in FY2005) continue their efforts to increase enrollment in SBHC sites. The DFH continues to support 10 Title X family planning clinics to provide confidential and low cost reproductive health services to teens through community-based providers. The DFH's WHSRP continues to provide no cost pregnancy testing and comprehensive health risk assessment and follow-up services to teens receiving pregnancy testing services in Title X clinics.

A Teen Pregnancy Prevention Coalition, is made up of both state and community based stakeholders, formed this year to develop a plan to address the need for access to care, primary and secondary prevention strategies, and comprehensive sexuality education. The DFH engaged the services of a student run consulting group called Youth Infusion to strengthen its structural capacity to involve youth in the development of programs and initiatives. Youth Infusion submitted a report with recommendations for engaging youth and will continue to provide TA to the DFH during the rest of FY2005. A website continues to provide parents of 9-17 year olds and providers with connections to RI programs and resources and includes monthly parenting tips. Promotional posters and mailing cards were developed and are distributed to build consumer utilization. Usability testing and a resulting revision of the site were recently completed.

The DFH also continues to support the Men 2B Program. Outreach materials continue to be used to increase Men 2B enrollment in worksites, schools, and faith-based organizations. A pilot project at the Men's Adult Correctional Institution is being implemented for men transitioning back to homes and communities.

Healthy Schools!/Healthy Kids! produced and disseminated issue briefs around weight management and physical activity, tobacco, alcohol and other drugs, sexual behavior, and injury and violence were produced to integrate data from the YRBS and SALT data sources. The DFH and other partners are collaborating on a violence prevention project called "Stop It". The DFH is also a member a suicide prevention task force. The task force developed a framework and objectives for Rhode Islanders ages 15 to 24 and now seeks funding to implement some of the strategies.

The DFH and other key partners developed a School Emergency Planning Preparedness, Response and Recovery Guide developed with the RIDE and the RIEMA. Guides will be distributed to all schools in CD format before the end of the school year. The RIAAP will be awarded a small grant to prepare pediatricians and schools to work together schools in case of an emergency event.

The DFH's SBHC Program continues to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. Fifty-four schools (including SBHCs) and alternative sites are currently participating in VBYG //2006//.

c. Plan for the Coming Year

/2006/ The DFH will continue to work to increase the percentage of 9th graders who are expected to graduate from high school. The Teen Pregnancy Coalition will serve a public policy, education and advocacy role with representation from both state and community based stakeholders. The group will implement strategies to facilitate improvements to adolescent access to care, to both primary and secondary pregnancy prevention efforts, and to implementation of comprehensive school sexuality education.

The DFH will implement strategies recommended by Youth Infusion to involve youth in the development of programs. A website will continue to provide parents 0f 9-17 year olds and providers with connections to RI programs and resources and includes monthly parenting tips. The web site will be promoted as part of a coordinated communications strategy to promote the Men2B program, Can We Talk and Plain Talk in work sites, faith organizations and schools.

The DFH will continue to support the Men 2B Program. Program quality will be a focus of effort and evaluation data will continue to inform improvement. A pilot project at the Men's Adult Correctional Institution implemented for men transitioning back to homes and communities will be evaluated and continued if effective.

Plain Talk is intended to reduce teen birth rates and rates of sexually transmitted diseases. The DFH plans to implement and sustain a Plain Talk program in RI communities. The DFH will continue to work with other key partners on a violence prevention project called "Stop It". The DFH will continue to support 10 Title X family planning clinics to provide confidential and low cost reproductive health services. The DFH's WHSRP will continue to provide no cost pregnancy testing and comprehensive health risk assessment and follow-up services to teens receiving services in Title X sites. The DFH will continue to support 9 SBHCs in culturally diverse communities.

Healthy Schools!/Healthy Kids! will focusing on the following areas: 1) school smoking polices, 2) physical activity, obesity, and nutrition, 3) school health data needs, 4) implementation of school rules and regulations, 5) professional development, 6) school environmental health, 7) community schools/out-of-school time programming, and 8) developing and strengthening relationships with community partners.

The DFH's SBHC Program will continue to collaborate with the DFH's Immunization Program on the "Vaccinate Before You Graduate" (VBYG) initiative. VBYG will continue to be offered to any Rhode Island high school. In FY2006, the new meningococcal conjugate vaccine will be offered to both 9th and 12th graders //2006//.

State Performance Measure 7: *Percent of children in the Early Intervention Program with Individual Family Service Plans (IFSPs), discharged to Special Education, for whom an Individual Education Plan (IEP) is developed.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80.0	71.5	72.5	73.5	75
Annual Indicator	73.1	66.8	68.1	80.5	83.1
Numerator	274	257	333	488	545
Denominator	375	385	489	606	656
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	82	82

Notes - 2002

Calendar year used and data for 2000 and on are estimated.

In 2001, a Transition Co-ordinator was hired to work with the EI Sites and the Department of Education to facilitate the transition process. This should produce more reliable data and the timely development of Individual Education Plans [IEPs].

2002: A transition network committee team has started to meet to discuss problem areas around transition and are in the process of developing a transition plan form that will be implemented statewide in the next year.

Notes - 2003

2003: Calendar year used. In 2001, a Transition Co-ordinator was hired to work with the EI Sites and the Department of Education to facilitate the transition process. This has produce more reliable data and the timely development of Individual Education Plans [IEPs].

Notes - 2004

Calendar year used. In 2001, a Transition Co-ordinator was hired to work with the EI Sites and the Department of Education to facilitate the transition process. This has produce more reliable data and the timely development of Individual Education Plans [IEPs].

a. Last Year's Accomplishments

/2006/ During FY2004, the administration of the Early Intervention (EI) Program was transferred from the DFH to the Rhode Island Department of Human Services (RIDHS).

The DFH's Office for Families Raising Children with Special Health Care Needs (OFRCSHCN) has been integral in the transition in supporting a seamless transition for infants, toddlers, and their families enrolled in EI.

During FY2004, the RIDHS adopted the standards, regulations, policies, and procedures utilized by the DFH in administering the EI Program and these standards, regulations, policies, and procedures included transition planning for children leaving EI and entering Special Education. As a result, the seven statewide EI sites continued to provide comprehensive transition services for CSHCN reaching the age of three years //2006//.

/2005/ The EI Program continued to implement transition goals to ensure that timelines specified in IDEA were met. Transition planning for IEP development begins on or before a child's 30th month of life and is completed by the child's 36th month. Regional EI Program parent consultants continued to support families with CSHCN at transition meetings and informed them about EI procedural safeguards //2005//.

/2006/ A transition coordinator position was developed jointly between EI and the Rhode Island department of Education (RIDE), which administers special education services for students ages 3 through 2 years. This new position has helped to enhance the transition process //2006//. /2005/ Transition meetings occurred on an on-going basis to address systems issues related to transition and aggregate information was shared with the Inter-Agency Coordinating Council (ICC), which includes the information in its annual report //2005//. ***/2006/The ICC is made up of EI agencies, families with children receiving EI services, state legislators, representatives of the Rhode Island Department of Health (HEALTH), RIDHS, the Rhode Island Department of Children, Youth, & Families (DCYF), RIDE, and others. In FY2004, the DFH's Birth Defects Program worked with the EI Program to share data on children with birth defects who are referred and/or enrolled in EI //2006//***.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Is working with the RI Department of Human Services (RIDHS) on issues related to the transfer of the Early Intervention Program from the DFH to the RIDHS in 2004.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2006/ During FY2004, the administration of the early Intervention (EI) Program was transferred from the DFH to the Rhode Island Department of Human Services (RIDHS). The DFH's OFRCSHCN has been integral in this transition in supporting a seamless transition for infants and toddlers and their families enrolled in EI. During FY2004, the RIDHS adopted the standards, regulations, policies, and procedures from the DFH in administering the EI Program. These regulations include transition planning for toddlers leaving EI and entering special education, which is the responsibility of the Rhode Island Department of Education (RIDE).

The 7 statewide Early Intervention (EI) sites continue to provide comprehensive transition services for CSHCN reaching the age of three years //2006//. /2005/ The EI Program continues to implement transition goals to ensure that timelines specified in IDEA are met. Transition planning for IEP development begins on or before a child's 30th month of life and is completed by the child's 36th month. Transition meetings occur on an on-going basis to address systems issues related to transition and this information continues to be shared with the Inter-Agency Coordinating Council, which includes the information in its annual report. Regional EI Program parent consultants continue to support families with CSHCN at transition meetings and inform them about EI procedural safeguards //2005//. ***/2006/ The transition coordinator position was developed jointly between EI and the RI Department of Education (RIDE) /2006//. /2005/ This new position helps to enhance the existing transition process //2005//.***

c. Plan for the Coming Year

/2006/ The Rhode Island Department of Human Services (RIDHS) has had responsibility for administering the Early Intervention (EI) since FY2004. The RIDHS is in the process of revising and releasing certification standards for full-service EI providers, which will include standards concerning the transition of children from EI to Special Education. The DFH's OFRCSHCN will have a role in the development and adoption of these standards and will continue to advocate for a seamless transition from EI to Special Education, as appropriate //2006//.

State Performance Measure 8: *[REVISED:] The percentage of children age 2 years and above in the WIC Program who are overweight (high weight for stature) and infants and children who are underweight (low weight for stature).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20	45	23	14	14
Annual Indicator	26.1	50.5	21.9	11.2	12.9
Numerator	4848	9200	4128	2093	2344
Denominator	18580	18228	18864	18745	18217
Is the Data Provisional or				Final	Final

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.5	13	12.5	12.5	

Notes - 2002

During FY99, the WIC Program instituted national risk criteria with standardized definitions of specific risks resulting in:
the risk definition of overweight dropped from >=95th percentile to >=90th percentile; and the risk definition for underweight infants dropped from <=25th percentile to <=10th percentile.
FY99 data reflect these changes and show an increase in the proportion of children and infants enrolled in WIC who are either overweight or underweight.

2001: The increase seen in 2001 is largely due to changes in WIC programming; now all eight risk criteria are included whereas, in previous years, only the first listed was captured by the system.

2002: The WIC program now defines overweight as Body Mass Index [BMI] >= 95th percentile or weight for height >= 95th percentile for children 2 years or older using stature height. WIC now includes an additional risk factor for determining overweight and infants are no longer included in the over weight category.
2002 WIC data should be considered an estimate.

Due to these changes, Annual Performance Objectives have been lowered.

Notes - 2003

During FY99, the WIC Program instituted national risk criteria with standardized definitions of specific risks resulting in:
the risk definition of overweight dropped from >=95th percentile to >=90th percentile; and the risk definition for underweight infants dropped from <=25th percentile to <=10th percentile.
FY99 data reflect these changes and show an increase in the proportion of children and infants enrolled in WIC who are either overweight or underweight.

2001: The increase seen in 2001 is largely due to changes in WIC programming; now all eight risk criteria are included whereas, in previous years, only the first listed was captured by the system.

2002: The WIC program now defines overweight as Body Mass Index [BMI] >= 95th percentile or weight for height >= 95th percentile for children 2 years or older using stature height. WIC now includes an additional risk factor for determining overweight and infants are no longer included in the over weight category.

2003: Data for 2003 continues to be a reflection of the increase in Body Mass Index [BMI] from 90 % to 95%.
WIC data should be considered an estimate.

Notes - 2004

2004: Data for 2004 continues to be a reflection of the increase in Body Mass Index [BMI] from 90 % to 95%.
WIC data should be considered an estimate.

a. Last Year's Accomplishments

/2006/ Last year, the WIC Program revised its definition of overweight and excluded infants (i.e. less than two years of age) and children in the 90-94th percentile. Based on this revised definition, it was determined that 19% of children were overweight in

WIC //2006//.

/2005/WIC continued to provide specialized foods packages based on individual needs and educate WIC participants about basic nutrition and the importance of physical activity //2005//. ***/2006/ During FY2004, WIC continued to focus on the development of local WIC staff counseling skills designed to empower families in coping with the issue of childhood obesity //2006//***. /2005/ WIC also continued to participate in a community-based coalition to develop anticipatory guidance for childhood obesity prevention. The goal of the coalition is to implement and sustain a long-term approach to pediatric obesity prevention and management in RI.

The DFH's Communication Unit worked collaboratively with the WIC Program during FY2003 to revitalize WIC nutrition informational materials. Materials were revised based on demand and utilization rates. Local WIC nutritionists along with DFH parent consultants assisted the Communication Unit with the development of informational materials //2005//. ***/2006/ The WIC Program distributed the revised culturally and linguistically appropriate materials through local WIC sites throughout FY2004 //2006//***. /2005/ DFH parent consultants also continued to play a key role in coordinating WIC outreach and other activities to ensure that they are culturally and linguistically competent.

The DFH's Farmers Market Nutrition Program (FMNP) continued to provide low-income families, including those participating in WIC, in urban areas with access to fresh fruits and vegetables //2005//. ***/2006/ In FY2004, 20,491 individuals throughout the state received FMNP benefits, which represents an increase of 16% over FY2003 //2006//***. /2005/ All FMNP participants received helpful hints on storing and shopping for fresh produce and recipes for preparing fresh produce. "Veggin' Out" multi-cultural cooking demonstrations, sponsored by volunteer chefs, were held at several FMNP sites. The DFH supported translators at FMNP sites, as appropriate //2005//. ***/2006/ The DFH's WIC Program, in partnership with the DFH's Communications Unit, and Johnson & Wales University, distributed a newly developed culturally and linguistically appropriate "Veggin' Out" recipe book for distribution at local Farmers Markets.***

The DFH's Immunization Program hosts an annual conference for over 450 school nurse teachers and childcare providers involved with children from childcare settings to high school. This year's theme was the psychosocial aspects of childhood obesity//2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to assess the BMI status of children ages 2 years and above through the WIC and Immunization Programs.			X	
2. Continues to provide specialized food packages based on individual needs and educate enrollees about basic nutrition and the importance of physical activity, through WIC.		X		
3. Continues to provide local WIC staff with training to enhance counseling skills designed to empower families in coping with childhood obestiy.		X		

4. Continues to participate in a community-based coalition to develop anticipatory guidance for childhood obesity prevention in RI.				X
5. Continues to revitalize WIC nutritional educational materials for culturally diverse populations.			X	
6. Continues to support culturally diverse parent consultants to assist with the development of revitalized WIC nutritional edcuational materials.				X
7. Continues to provide culturally diverse low-income families in urban areas with access to fresh fruits and vegetables through the Farmers Market Nutrition Program (FMNP).		X		
8. Continues to provide recipes for preparing fresh fruits and vegetables to culturally diverse low-income families through "Veggin' Out" cooking demonstrations.		X		
9. Revised a linguistically and culturally appropriate "Veggin" Out" cook book to include nutrition information for each recipe.		X		
10. Conducted surveys to determine customer satisfaction with and effective of the FMNP.			X	

b. Current Activities

/2006/ Data from the WIC Program indicate that 23.4% of children ages 2-5 enrolled in WIC during 2004 had BMIs > the 95th percentile. WIC data were based on revised national growth standards. Height and weight data collected by the Immunization Program through clinical assessments of children entering Kindergarten in 2004 indicate that 17.0% had BMIs > the 95th percentile. The DFH's Data & Evaluation Unit is working with staff from HEALTH's Division of Disease Prevention and Control (DDPC) to examine WIC Program data to determine the factors associated with overweight children, ages 2-5 years, enrolled in WIC.

In FY2005, WIC continues to provide specialized foods packages based on individual needs and educate WIC participants about basic nutrition and the importance of physical activity. WIC has been focusing on the development of local WIC staff counseling skills designed to empower families in coping with the issue of childhood obesity. WIC also continues to participate in a community-based coalition to develop anticipatory guidance for childhood obesity prevention. The goal of the coalition is to implement and sustain a long-term approach to pediatric obesity prevention and management in RI.

The DFH's Communication Unit continues to work collaboratively with the WIC Program to revitalize WIC nutrition informational materials. Materials are being revised based on demand and utilization rates. New informational materials focusing on healthy eating for all WIC participant categories have been completed, and will be disseminated to WIC nutritionists in June 2005 so they can begin distributing them to WIC participants. The focus of these materials is building healthy feeding relationships, which will partner nicely with the physical activity materials currently being developed. Local WIC nutritionists along with DFH parent consultants continue to assist the Communication Unit with the development of informational materials. DFH parent consultants play a key role in coordinating WIC outreach and other activities to ensure that they are culturally and linguistically competent.

The DFH's Farmers Market Nutrition Program (FMNP) continues to provide low-income families in urban areas with access to fresh fruits and vegetables. During FY2005, 21,736 individuals throughout the state received FMNP benefits. All FMNP participants continue to receive helpful hints on storing and shopping for fresh produce and recipes for preparing fresh produce. "Veggin' Out" cooking demonstrations, sponsored by volunteer chefs, continue to be held FMNP at sites. The DFH continues to support translators at

FMNP sites, as appropriate. Culturally and linguistically appropriate "Veggin' Out" cookbooks have been revised to include nutrition information for each recipe included in the cookbook. Participant surveys were conducted in FY2005 to determine customer satisfaction and effectiveness of the FMNP //2006//.

c. Plan for the Coming Year

/2006/ The DFH's Data & Evaluation Unit will continue to analyze data related to Body Mass Index (BMI) from the RI Health Interview Survey, the WIC Program, and the Immunization Program. They will also continue to work with the WIC Program and HEALTH's division of Disease Prevention & Control (DDPC) to study the factors (e.g. race/ethnicity, town of residence, maternal characteristics, etc.) associated with childhood obesity.

In FY2006, WIC will continue to provide specialized foods packages based on individual needs and educate WIC participants about basic nutrition and the importance of physical activity. With the implementation of new WIC computer software, food packages can be further tailored to meet participant nutrition needs (assignment of low fat milk/cheese), which will help enforce healthy eating food choices for achieving healthy weights. Implementation of this software is scheduled to be launched in September of 2005.

WIC will also continue to participate in a community-based coalition to develop anticipatory guidance for childhood obesity prevention. The goal of the coalition is to implement and sustain a long-term approach to addressing childhood obesity prevention and management in RI. WIC will continue to provide training to local and state WIC staff, and collaborate with other key partners in focusing on family dynamics and its impact on childhood obesity. WIC will utilize FY2006 to research programs from other states, including FIT WIC, and pilot some strategies in local RI WIC sites.

The DFH's Communication Unit will continue to work collaboratively with the WIC Program to revitalize WIC nutrition informational materials and improve the current WIC Allowed Food List. Materials will continue to be revised based on demand and utilization rates. The DFH will utilize FY2005 to refine the WIC website for diverse audiences, including current WIC participants, potential WIC participants, and WIC venders. DFH parent consultants will continue to assist the Communication Unit with the development of informational materials. DFH parent consultants will continue to play a key role in coordinating WIC outreach and other activities to ensure that they are culturally and linguistically competent.

The DFH's Farmers Market Nutrition Program (FMNP) will continue to provide low-income families, including those participating in WIC, in urban areas with access to fresh fruits and vegetables. All FMNP participants will continue to receive helpful hints on storing and shopping for fresh produce and recipes for preparing fresh produce. "Veggin' Out" cooking demonstrations, sponsored by volunteer chefs, will continue to be held FMNP sites. The DFH will continue to support translators at FMNP sites, as appropriate. Participant surveys will continue be conducted in FY2006 to determine customer satisfaction and effectiveness of the FMNP //2006//.

State Performance Measure 9: *Percentage of at risk (risk positive) newborns who receive*

a home visit from the Family Outreach Program during the early newborn period (<= 90 days old).

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	50	53	53.2	53.5	54
Annual Indicator	48.5	52.3	54.6	53.0	59.6
Numerator	2453	2946	3584	3588	4096
Denominator	5056	5638	6563	6768	6877
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	54.5	55	55	55	55

Notes - 2002

Data reflect calendar year and number of visits for 2000 declined, due to cut backs to the Home Visit Program.

Notes - 2004

Due to programming changing in the Home Visiting Database, 2004 data should be considered an estimate.

a. Last Year's Accomplishments

/2006/ The DFH's Family Outreach Program (FOP) provides home assessments, connection to community supports, and help with child development and parenting for almost one-third of all families with newborns each year. The DFH defines the early newborn period as being up to 90 days after an infant is born, since most premature and low birth weight infants are not discharged from the hospital immediately after birth. Home visitors also serve as the follow-up mechanism for the DFH's Newborn Screening, Lead Poisoning, and Immunization Programs.

A little more than half of newborns in the state qualify for FOP services. Home visits are voluntary, but if the family accepts the visit, there are seen within 7 days of discharge from the hospital. Priority referrals are seen within 24 hours of discharge. KIDSNET tracks all at-risk newborns to ensure that they have a Level II screening through the DFH's Newborn Screening Program and, if appropriate, referral to the RIDHS's Early Intervention (EI) Program. Developmental risk factors include maternal age status under 19 or over 37 years, first baby status, and maternal education status < 11th grade. The majority of children eligible for EI services are identified through the state's "Child Find" infrastructure, which includes the FOP.

"Hard-to-reach" families, including those who move frequently, are of particular concern. In FY2004, the DFH's EI Program provided additional funding to the FOP to provide outreach to "hard-to-reach" families. In addition, the DFH's Communication Unit developed new culturally and linguistically appropriate informational brochures for

families about the FOP in English and in Spanish. 300 additional hours of training was provided to FOP home visitors on the issues and needs of "hard-to-reach" families. FOP data suggests an improvement in the acceptance rate for this population.

The DFH's Birth Defects Program collaborates with the FOP to ensure that children with birth defects receive appropriate services and referrals. Data from the birth defects surveillance system were compared with data from selected FOP organizations to determine referrals //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to support the Family Outreach Program (FOP) which provides home assessments, connection to community supports, and help with child develpment and parenting to about 1/3 of all families with newborns in RI.				X
2. Continues to support the FOP as the follow-up mechanism for several MCH programs, including newborn screening, lead poisoning, and immunization.				X
3. Continues to utilize KIDSNET to generate electronic referrals to the FOP based on Level I newborn risk screening activities.				X
4. Continues to refer eligible infants to the Early Intervention (EI) Program through the FOP.				X
5. Linked data from the birth defects database with KIDSNET to determine the number of infants with a birth defect who received FOP home visiting services.				X
6. Developed culturally and lingusitically appropriate informational materials about the FOP.			X	
7. Provided training to FOP home visitors on the issues and needs of "hard-to reach" families.		X		
8.				
9.				
10.				

b. Current Activities

/2006/ The DFH's Family Outreach Program (FOP) continues to provide home assessments, connection to community supports, and help with child development and parenting for almost one-third of all families with newborns. The DFH continues to define the early newborn period as being up to 90 days after an infant is born, since most premature and low birth weight infants are not discharged from the hospital immediately after birth. Home visitors also continue to serve as the follow-up mechanism for the DFH's Newborn Screening, Lead Poisoning, and Immunization Programs. KIDSNET generates daily electronic referrals to the FOP for infants identified to be at developmental risk.

Home visits are voluntary, but if the family accepts the visit, there are seen within 7 days of discharge from the hospital. Priority referrals are seen within 24 hours of discharge. KIDSNET continues to track all at-risk newborns to ensure that they have a Level II screening through the DFH's Newborn Screening Program and, if appropriate, referral to the RIDHS's Early Intervention (EI) Program. The majority of children eligible for EI services are identified through the state's "Child Find" infrastructure, which includes the FOP. KIDSNET data is being utilized to help develop a newborn risk assessment CQI plan, which will include the FOP.

The DFH's Birth Defects Program continued to work with the DFH's FOP to ensure that children with birth defects receive appropriate services and referrals. Data from the birth defects database were linked to KIDSNET to determine the number of families of babies with a birth defect who received home visits and service referrals.

In addition, the DFH's Communication Unit developed new culturally and linguistically appropriate informational brochures for families about the FOP. 300 additional hours of training was provided to FOP home visitors on the issues and needs of "hard-to-reach" families. FOP data suggests an improvement in the acceptance rate for this population //2006//.

c. Plan for the Coming Year

/2006/ The DFH's Family Outreach Program (FOP) will continue to provide home assessments, connection to community supports, and help with child development and parenting for almost one-third of all families with newborns in FY2004. The DFH will continue to define the early newborn period as being up to 90 days after an infant is born, since most premature and low birth weight infants are not discharged from the hospital immediately after birth. Home visitors will also continue to serve as the follow-up mechanism for the DFH's Newborn Screening, Lead Poisoning, and Immunization Programs. KIDSNET will continue to generate daily electronic referrals to the FOP for infants identified to be at risk for developmental delay.

A little more than half of newborns in the state qualify for FOP services. Home visits will continue to be voluntary and, if the family accepts the visit, they will continue to be seen within 7 days of discharge from the hospital. Priority referrals will continue to be seen within 24 hours of discharge. KIDSNET will continue to track all at-risk newborns to ensure that they have a Level II screening through the DFH's Newborn Screening Program and, if appropriate, referral to the RIDHS's Early Intervention (EI) Program. The majority of children eligible for EI services are identified through the state's "Child Find" infrastructure, which includes the FOP.

The DFH will continue to use an electronic integrated birth certificate and developmental risk assessment at all maternity hospitals in RI. This initiative helps cross check that all babies are included and sent to KIDSNET. KIDSNET will continue to generate electronic referrals for all at-risk infants. KIDSNET will continue to proved support in data analysis and respond to FOP data requests. To increase the number of families accepting home visits, families will receive information about the FOP prenatal or in the hospital prior to discharge. Culturally and linguistically appropriate informational brochures about the FOP that were developed by the DFH's Communication Unit in FY2003 will be used for

this purpose.

The DFH's Birth Defects Program will continue to work with FOP organizations to ensure that children with birth defects receive appropriate services and referrals. The Birth Defects Program will continue to work with the Birth Defects Advisory Council to implement a referral process for infants with sentinel conditions to assure outreach and follow-up. In FY2006, babies identified with sentinel conditions will continue to be referred to the FOP to ensure that they have "medical homes" and receive appropriate referrals to other support services //2006//.

State Performance Measure 10: *Number of family surveys completed*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1200	1350	1500	2000	2500
Annual Indicator	1790	1997	2904	3215	5019
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3000	3500	3500	3700	3700

Notes - 2002

Data reflect calendar year totals.
This performance measure was developed to capture the final number of surveys completed versus a response rate. Therefore, this measure is not a proportion or percentage, rather it is a number. Since the goal of this performance measure, as described in Form 16--Detail Sheet, is to increase family input, the increase in the number of completed surveys is the desirable outcome (not number of total attempts).

Prior to FY99, surveys were administered by Division of Family Health parent consultants on a face-to-face basis. The number of total surveys was targeted.

During FY99, a survey was developed and administered to families with children in child care centers. This was a targeted survey.

As of FY00, the majority of the surveys were conducted by telephone with targeted random samples. The surveys were conducted until the target number was reached. FY00 [calendar year 2000] has been updated with the final total.

2001 and on: Family surveys were conducted by many of the programs in Family Health, including WIC, Immunization, Lead, Early Intervention, SSI and the Communications Unit. The selection criteria for clients surveyed varied depending on the purpose of the survey. The survey methods used included written and telephone surveys, intercept interviews and focus groups. Survey topics ranged from program development, testing program materials, barriers to services and satisfaction with services received. Starting with 2002, data also includes the number of completed PRAMS surveys received in that calendar year.

Notes - 2003

Data reflect calendar year totals.
This performance measure was developed to capture the final number of surveys completed versus a response rate. Therefore, this measure is not a proportion or percentage, rather it is a number. Since the goal of this performance measure, as described in Form 16--Detail Sheet, is to increase family input, the increase in the number of completed surveys is the desirable outcome (not number of total attempts).

2003: Family surveys were conducted by many of the programs in Family Health, including WIC, Lead, Early Intervention, SSI and the Communications Unit. The selection criteria for clients surveyed varied depending on the purpose of the survey. The survey methods used included written and telephone surveys, intercept interviews and focus groups. Survey topics ranged from program development, testing program materials, barriers to services and satisfaction with services received. Starting with 2002, data also includes the number of completed PRAMS surveys received in that calendar year.

Notes - 2004

Data reflect calendar year totals.
This performance measure was developed to capture the final number of surveys completed versus a response rate. Therefore, this measure is not a proportion or percentage, rather it is a number. Since the goal of this performance measure, as described in Form 16--Detail Sheet, is to increase family input, the increase in the number of completed surveys is the desirable outcome (not number of total attempts).

2004: Family surveys were conducted by many of the programs in Family Health, including WIC, Lead, Early Intervention, SSI, Family Planning and the Communications Unit. The selection criteria for clients surveyed varied depending on the purpose of the survey. The survey methods used included written and telephone surveys, intercept interviews and focus groups. Survey topics ranged from program development, testing program materials, barriers to services and satisfaction with services received. Starting with 2002, data also includes the number of completed PRAMS surveys received in that calendar year.

a. Last Year's Accomplishments

/2006/ In FY2004, the DFH received input though 3,119 completed surveys from culturally diverse consumers and/or families (including families with CSHCN) through a variety of strategies (this number will actually be higher once the remainder of FY2004 PRAMS surveys have been data entered).

The DFH's WIC Program conducted its annual survey to determine the nutrition education needs of WIC participants and customer satisfaction with WIC services. The WIC Program received 704 completed surveys from WIC participants (484 in English and 220 in Spanish). WIC also conducted a survey of 394 individuals who participated in the FMNP during FY2004. The DFH's Parent Consultant Program collaborated with the WIC

Program to conduct 45 one-on-one parent surveys about the quality of WIC services as a part of the WIC Program's annual management evaluations of local WIC agencies.

The DFH's OFRCSHCN conducted a survey of English and Spanish speaking parents whose CSHCN are being served through the PPEP. The purpose of this survey was to obtain a baseline on the performance of each of the practices in providing care to CSHCN within a "medical home". This effort resulted in 393 completed surveys. The DFH's surveyed families to assess how comfortable they feel answering questions about their racial and ethnic affiliation. This effort resulted in 90 completed surveys.

Successful Start conducted five focus groups with 51 culturally diverse parents with young children to obtain input on the needs of culturally diverse families with young children. Of the 51 parents who participated in the focus groups, 31% spoke English, 26% spoke Spanish, and 43% spoke one of two Southeast Asian languages.

The Family Planning Program conducted surveys of racially and ethnically diverse young men, less than 19 years old who received family planning services through a Title X family site. Of the 67 young men who received services during this period, 60 completed a survey (89.5%).

Child Opportunity Zone (COZ) families completed 800 health surveys. The DFH's Mt. Hope CATCH initiative completed 120 parent surveys and 6 focus groups focusing on "medical homes". Newport CATCH engaged 100 families in "medical home" discussion groups. Washington County CATCH completed 145 parent surveys, 60 key informant interviews and 7 parent interviews focusing on children's mental health issues.

The Communications Unit conducted interviews/focus groups with 152 culturally diverse parents/ individuals on behalf of several DFH programs, including the OFYSS, WIC, TWOS, Newborn Screening, and OFRCSHCN. PRAMS Program has received nearly 3,000 completed surveys from women who delivered during 2002 and 2003. Data continue to be collected and responses among women who gave birth in 2004 are still being entered into the PRAMS database //2006//.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continues to conduct an annual survey of culturally diverse WIC participants.			X	
2. Continues to conduct an annual survey of culturally diverse Farmers Market Nutrition Program (FMNP) participants.			X	
3. Continues to utilize culturally diverse parent consultants to conduct one-on-one interviews with WIC participants as a part of the WIC Program's annual local management evaluation process.			X	
4. Conducted formative research in 4 schools with parents, school staff, and students related to environmental conditions and access to health care services in schools.			X	
5. Is planning to obtain parent input on modifying a "medical home" algorithm of the newborn hearing screening and diagnostic process into a family-friendly format for distribution to families.			X	
6. Continues to survey culturally diverse young men under age 19 who			X	

recieve family planning services through a Title X site.				
7. Continues to survey culturally diverse clients and potential clients of Title X family planning services as a part of the annual Title X community input process.			**X**	
8. Is planning to utilize a parent consultant to interview culturally diverse clients as a part of the annual Title X site review process.			**X**	
9. Continues to obtain input from families and other consumers as a part of the development of educational materials and other communications strategies.			**X**	
10. Continues to survey women who recently gave birth through PRAMS and mothers of 2-year olds through TWOS.			**X**	

b. Current Activities

/2006/ In FY2005, the DFH continues to receive input from culturally diverse consumers and/or families through a variety of strategies. The WIC Program is conducting its annual survey of WIC participants. It is also conducting a survey of individuals who participate in the FMNP. The Parent Consultant Program continues to collaborate with the WIC Program to conduct one-on-one parent surveys as a part of the WIC Program's annual management evaluations of local WIC agencies.

The OFYSS conducted formative research in four schools with school staff, parents, and students related to environmental conditions and access to health services. In the schools we did do, school staff, parents and students were queried separately. The Newborn Hearing Screening is planning to get parent input on modifying a "medical home" algorithm of the hearing screening and diagnostic process into a family friendly format for distribution to families.

The Family Planning Program continues to survey young men who receive family planning services through a Title X family site. The Family Planning Program is also in the process of disseminating a survey to consumers/potential consumers of family planning services throughout the state as a way to obtain community input about Title X family planning programs and services. In FY2005, the Parent Consultant Program will collaborate with the Family Planning Program to conduct one-on-one client surveys as a part of the Family Planning Program's annual site review process of local Title X sites.

The Communications Unit continues to routinely obtain input from families and other consumers when it develops educational materials and other communications strategies for DFH programs. This year it is working with the OFYSS, Newborn Screening, and OFRCSHCN. Successful Start continues to include families in the design, delivery, and evaluation of services they receive.

PRAMS continues to survey women who have recently given birth. Data continue to be collected for FY2005 and responses among women who gave birth in 2004 are still being entered into the PRAMS database. Once completed, these data will be sent to CDC for weighting. The TWOS survey was launched in March 2005 and data are currently being collected //2006//.

c. Plan for the Coming Year

/2006/ In FY2006, the DFH will continue to receive input from culturally diverse consumers and/or families through a variety of strategies. The WIC Program will conduct its annual survey of WIC participants. WIC will also continue to conduct a

survey of individuals who participate in the FMNP. The Parent Consultant Program will continue to collaborate with the WIC Program to conduct one-on-one parent surveys as a part of the WIC Program's annual management evaluations of local WIC agencies.

The Family Planning Program will continue to survey young men who receive family planning services through a Title X family site. The Family Planning Program will also conduct a survey targeting consumers/potential consumers of family planning services as a way to obtain community input about Title X family planning programs and services. The Parent Consultant Program will continue to collaborate with the Family Planning Program to conduct one-on-one client surveys as a part of the Family Planning Program's annual site review process of local Title X sites.

The Communications Unit will continue to routinely obtain input from families and other consumers when it develops educational materials and other communications strategies for DFH programs. Successful Start will continue to conduct focus groups and surveys with families in multiple languages during the implemention phase in FY2006. The Newborn Hearing Screening is utilizing FY2005 to plan to get parent input on modifying a "medical home" algorithm of the hearing screening and diagnostic process into a family friendly format for distribution to families. This input will be obtained during FY2006.

The Data & Evaluation Unit will continue to conduct PRAMS and TWOS, analyze data, and work with the PRAMS Steering Committee for reporting and data dissemination. The information collected through PRAMS and TWOS will continue to address many national and state performance measures, including those related to prenatal care, breastfeeding, genetics, lead screening, immunization, and health insurance //2006//.

E. OTHER PROGRAM ACTIVITIES

/2004/ Toll-Free Family Health Information Line

The DFH supports a statewide toll-free telephone resource for all families in Rhode Island. Bi-lingual information specialists answer families' questions in English and in Spanish on a wide variety of topics and refer them to appropriate community resources. Culturally and linguistically appropriate consumer informational materials will continue to de disseminated through the DFH's centralized distribution center //2004//.

/2006/ Called the Family Health Information Line, this resource received a total of 3,713 calls during the period 1/1/04-6/30/04. 29.43% of the calls were related to WIC; 23.60% to immunizations; 15.93% to lead poisoning; 10.93% to non-DFH topics; 6.54% to mold and mildew; 3.29% to bio-terrorism; 2.85% to Early Intervention; 2.58% to family planning; 1.02% to adolescent health; 0.86% to PRAMS; 0.81% to disabilities; 0.73% to KIDSNET; 0.54% to West Nile Virus; and 0.38% to child care.

86.61% of the callers were consumers, 4.69% were health care providers, 3.58% were social service providers, 2.75% were childcare providers, 1.62% were school personnel, 0.65% were WIC vendors, and 0.13% were legislators or the media. 82.69% of the callers were English-speaking, 16.55% were Spanish-speaking, and 0.75% were Portuguese-speaking. The majority of callers (47.78%) found out about the Family Health Information Line through a printed informational brochure or through a direct mailing. 13.48% found out about it through another state agency; 11.26% through the telephone book or directory assistance; 9.39% through television, radio, newspaper, outdoor advertisement, or internet; 8.46% through a health care provider or health plan; 8.16% through a relative or friend, 0.22% through a community-based

organization; 0.22% through incentives; 0.17% through printed informational materials; 0.14% through an unknown source; and 0.05% through the passage of the new lead law //2006//.

F. TECHNICAL ASSISTANCE

/2004/ Technical Assistance FY2004

1. GENERAL SYSTEMS CAPACITY ISSUES: Technical assistance is requested for expanded use of national and state survey data in planning, management, and evaluation of critical Family Health investments. This request responds to our identified priorities in needs assessment, community capacity building, and communication, and addresses several national and state performance measures, as well as our data capacity needs.

Assistance is needed because Rhode Island has committed to prompt sophisticated use of survey data for public health leadership and accountability. We have developed extensive survey data within the state (PRAMS, Parent surveys, YRBS, state HIS, SALT survey of schools) and national data (SLAITS, Immunization) is available to inform MCH policy, as well. Completing a plan to use these data effectively for Family Health leadership, and engagement of academic and other partners in the work, will be the objective of this TA.

Preliminary discussions with Prof Milton Kotelchuck of the Boston University School of Public Health indicates that this assistance would be an appropriate expansion of their expanding support relationship to New England states.

2. NATIONAL AND STATE PERFORMANCE MEASURES: Technical assistance is requested in developing and staffing a broad state analysis and plan to address increasing rates of premature and VLBW births. As in other parts of the country, Rhode Island has disturbing increases in babies born too early and too small. Despite high levels of Medicaid coverage and enrollment in prenatal care, and an excellent system for managing high-risk pregnancies and sick newborns, this fundamental measure of pregnancy outcomes (and public health) is moving in the wrong direction. This request addresses SPM 4 and NPM 15,17, and 18.

Assistance is requested because there are important opportunities to engage nearby resources, both in Rhode Island and in New England, for excellent analysis and effective planning.

We propose to invite Dr Julius Richmond and several other members of the Massachusetts panel that studied infant mortality and designed the Mass Healthy Start program, for a day of preliminary discussions with Rhode Island leaders on keys to success with such an effort. Then we will likely request assistance to engage needed participation from the National Perinatal Information Center, for access to their excellent data on these issues in other comparable environments, and for analytic assistance //2004//.

/2005/ Technical Assistance FY2005 -- General Systems Capacity Issues Category

1. The DFH is requesting technical assistance to help better understand the provisions of HIPAA and FERPA in terms of health information & data collected by schools. The DFH needs to better understand constraints related to sharing data between the DFH and schools and develop strategies to facilitate sharing of health information and data with a goal of improving outcomes for students. The technical assistance will be done in consultation with Gail Hurlich of the national Immunization Program.
2. Technical assistance is requested for national champions for healthy child and human development. The DFH, the Rhode Island Department of Health, and the Children's Cabinet are all involved in strategic planning to incorporate modern models of child and human development into public health. To strengthen and support this opportunity, the DFH proposes to invite several national leaders of the SECCS projects and the recent IOM reports, as keynotes for public health forums and as consultants to the strategic planning teams. Examples of national leaders may include Doctors

Halfron, Shonkoff, and Stein.
3. Technical assistance is requested to help the DFH and its partners better understand how to include youth in programmatic and policy-making processes and to build effective youth/adult advocacy networks. As recipients of services and programming, youth have expertise to inform the planning and policy-making processes at state and local levels. Youth and adults need training and technical assistance to learn how to interact in meaningful productive ways and how to measure success. The technical assistance will be done in consultation with Youth Infusion (www.youthinfusion.com) //2005//.

/2006/ Technical Assistance FY2006 -- General Systems Capacity Issues Category

1. Successful Start, Rhode Island's State Early Childhood Comprehensive Systems (SECCS) Initiative, is working to coordinate and improve services in four critical areas of early childhood health and development: Early Care & Education, Medical Homes, Social-Emotional Development, and Parent Education & Family Support. The project is requesting technical assistance in implementing our goals and objectives relating to Parent Education and Family Support. Of the four critical areas of focus, the DFH has had the most difficulty in developing a plan to coordinate and improve services in this area. This is primarily due to the fact that the field of parent education and family support is not owned by any one state or other agency. In addition, parent support and education is very broad and encompasses a range of programs and services. Finally, there is no formal infrastructure to support capacity building, coordination, or quality improvement. Through this request for technical assistance, the DFH hopes to bring in external experts in this field to assist it in working through these challenges. This request primarily addresses the following early childhood related performance measures: NPM #1, NPM #2, NPM #5, NPM 3#, NPM #7, NPM #9, NPM #10, NPM #11, NPM #12, NPM #15, NPM #18, SPM #4, SPM #5, SPM #8, and SPM #10.
2. The Office of Communications & Policy is requesting technical assistance for training in the principles and techniques of continuous quality improvement (CQI). The Division of Family Health has convened a small CQI workgroup, which has begun to look at the Division's grants and contracts for evidence of CQI plans. The objective is to identify gaps and provide some basic TA to program managers around measuring and monitoring program effectiveness and improving program performance. Rhode Island's Director of Health has identified CQI as a crucial tool in reaching the Department's top priorities. This request addresses all of the DFH's national performance measures (NPMs) and state performance measures (SPMs) since it will benefit all of the DFH's MCH programs.
3. The State Legislature passed the Rhode Island Autism Spectrum Disorder (ASD) Evaluation and Treatment Act in this year's session. This legislation requires the Department's OFRCSHCN to take the lead in combating problems associated with ASD. The question for the technical assistance is how should the DFH approach this mandate since HEALTH does not offer or fund direct services for ASD, what the DFH's influence should be, and how the DFH can affect the policies and programming for families raising children with ASD. This request addresses the following CSHCN-related performance measures: NPM #3 and NPM #5.
4. The DFH would like to engage Holly Grason from the Women's and Children's Health Policy Center at Johns Hopkins to assist it in developing a maternal health agenda for the DFH. One of her better-known publications is "Charting a Course for the Future of Women's Health in the US". Ms. Grason is able to provide the DFH with information on best practices and help to guide the DFH in developing specific action steps that will flow from the objectives that the DFH will have developed by the end of the summer (FY2005). This request addresses the following maternal health related performance measures: NPM #17, NPM #18, and SPM # 4.
5. The Office for Family, Youth & School Success would like to develop a plan to help address the mental/behavioral needs of adolescents in school settings. Schools provide opportunities for early intervention. As part of that plan, the OFYSS, with partners, may want to implement a model program in one or more schools. The DFH would like to explore possibilities for Medicaid reimbursement and other strategies to support and sustain consultative services. The DFH would like to consider models for screening and integration of behavioral interventions in school based health centers, after-school programs and other school settings.

This request addresses the following adolescent behavioral health related performance measures: NPM #16 and SPM #6. In order to accomplish this, the DFH will need to work with partners in sister state agencies, in school districts, in health centers, and with others to develop a clear project vision and implementation plan. The DFH needs TA around start up strategies, engaging partners, choosing a model that is the right fit, integrating behavioral health services into the school setting and funding.

Suggestions for TA:

****Edward Joyner, Executive Director***
School Development Program at the Yale Child Study Center
55 College Street
New Haven, CT 06510
(203) 737-1020
fax (203) 737-4001

****Department of Health and Human Services***
Wilmington, North Carolina

****Sharon Thwing or Laura Heesacker***
United Community Health Center
Green Valley, Arizona
sthwing@uchcaz.org or lnheesacker@uchcaz.org //2006//.

V. BUDGET NARRATIVE

A. EXPENDITURES

/2006/BUDGET NARRATIVE-FY2006

EXPENDITURES

Federal Grant Monitoring Procedures

The Division of Family Health (DFH) maintains budget documentation for block grant funding/expenditures for reporting consistent with Section 505(a) and section 506(a)(1) for auditing. All federal grants are monitored both within Divisions and by HEALTH's Office of Management Services (OMS). The DFH's key administrator meets bi-weekly with DFH office and program chiefs to review spending, performance, and quality assurance issues for each federal grant. The OMS reviews each federal grant monthly for cost and data reporting issues. Any non-compliance, such as delays in progress reports or personnel hiring or lack of billing, requires an immediate response by the DFH's key administrator. Federal financial status reports (FSRs) are due within three months of the close of a federal grant. HEALTH consistently submits FSRs correctly and on-time.

HEALTH Policies for Contracting & Purchasing

Any purchase made with federal or state dollars requires prior approval. In addition, all purchases must be approved by the DFH's key administrator and office chief. Once approved, the request to purchase form must be signed by OMS staff and ten approved by the state Office of Purchasing. There are detailed policies for allowable and non-allowable purchases. These policies include restrictions on types of purchases, like gifts and food, as well as travel guidelines. There are procedures in place for the State of Rhode Island to assure that competition exists between all providers for federal and sate dollars. State departments are allowed to make some purchases without the approval of the Office of Purchasing under certain detailed guidelines. The DFH has established an inventory management plan that includes rules for purchasing of major equipment, monitoring equipment purchased with state dollars, and a plan for surplusing obsolete materials.

There are detailed procedures for establishing and monitoring contracts and grants at HEALTH. HEALTH staff cannot enter into a contract with a provider without following certain steps. There are two mechanisms for awarding funds at HEALTH: 1) through a competitive request for proposals (RFP) process and 2) through a grant based on need, legislative requirements or through a formula funding mechanism. There are detailed requirements for RFPs including appropriate language in the proposals, submission of offers, appeals, public review, and use of minority businesses. An RFP template must be followed for all RFPs and the document is reviewed by the DFH and the OMS before dissemination. The RFP process also requires a formal review of procedures used to select venders, including an independent session with Office of Purchasing staff. A grant may be awarded to a Rhode-Island-based non-profit agency for an identified need, if the agency is solely capable of addressing the need or if there is a legislative requirement to award funds to a particular agency or if HEALTH is awarding funds to all capable agencies through a funding formula. Once approval is received to enter into a grant, DFH staff must then follow procedures for establishing contracts.

Procedures for contract management includes the establishment and modification of contracts, which is the responsibility of the OMS, while the monitoring of contract compliance is a DFH responsibility. The DFH's chief of staff and key administrator meet with the DFH office chiefs to review contracts compliance and other administrative issues bi-weekly. Contract monitoring includes approval and signatures for appropriate charges to each contract and contract performance and progress. The DFH has routinely held back payments or terminated contracts for issues around performance and progress. The DFH's program managers must

review the appropriateness of all charges to the contract. Any variation in billing from the established contract must be requested in writing before reimbursements are made. DFH program managers are also responsible for the day-to-day oversights of contracts, monitoring performance, quality assurance, and billing procedures. The program managers regularly conduct performance reviews and customer satisfaction surveys for programs receiving state and federal funds.

Audits & Controls

Audits from both the state Office of the Auditor General and the state Bureau of Audits or conducted at HEALTH annually. The DFH has frequently been audited -- the WIC Program is audited annually and Early Intervention and Family Planning were audited in FY2000. HEALTH's OMS conducts audits of the DFH's contracts regularly and monitors payments. In addition to external audits, the DFH routinely audits all of its sub-contracted agencies and requires formal audits to be sent to the DFH annually.

HEALTH's division managers must submit an annual financial audit review to monitor controls on contracts, personnel, budget, and other administrative policies. These financial audits are reviewed by the state's Financial Officer for compliance with existing state policies. In the past, the DFH has completed a financial control review of its personnel and contracting policies. Corrections to these policies, such as documented procedure manual contracting and elimination of budgetary changes without written permission, have been instituted as a result of these financial control reviews.

Significant Year-To-End Expenditure Variations On Forms 3, 4, & 5

Form #3
Our expenditures for FY2004 increased from the amount budgeted to expended on Form #3 because of our unobligated balance from FY2003. Most of the expenditures for FY2004 were for services for children with special needs. The division relies on this prior year balance to fund new initiatives and unplanned expenditures. FY2004 unobligated balance is higher than estimated because of significant carry-forward from FY2003. Expenditures from Program Incomes decreased significantly due to national vaccines shortage. The Division could not purchase the anticipated amount of vaccines.

Form #4

Portion of the unobligated balance from FY2003 was invested in pregnant women. Small investments were made in young male population in the Men to be program and in improving administrative systems. Fewer resources were expended in infants due to major investments in Children Preventive Services and CSHCN investments.

Form #5
Investments for FY2004 moved away from Direct Services to Enabling and Infrastructure Building Services. Population-Based Services expenditures were lower than budgeted due to National Vaccines shortage. The Division could not purchase the expected amount of vaccines //2006//.

B. BUDGET

/2006/ BUDGET NARRATIVE-FY2006

BUDGET

Title V expenditures for FY2004 were 33.06% to preventive services for children, 39.29% to

children with special health care needs, and 5.90% for administrative costs. In FY2006, the Division proposes to spend $1,768,713 including a carry-forward of $190,150 from FY2005. Our Office of Children with Special Health Care Needs has addressed the needs of vulnerable young children and adolescent, investing in Early Intervention, parent involvement and system building during FY04 and FY05. Family Health continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. Family Health's Year 2006 budget allocates $1,768,713, of which 31.7% ($560,698) will be expended on preventive services for children, 37.67% ($666,271) will be expended for children with special care needs and 5.66% ($100,114) was allocated for administrative costs. The Division's MCH budget for FY2006 is $38,701,048, with $3,001,829 allocated from state resources not including program income and private funds. The Division's total budget for FY2006 represents a reduction of $6,837,169 in Early Intervention (EI), SPRANS, SSDI, and CDC funds.

Due to a large expenditure for children with special health care needs, the Division expended $8,761,310 in FY2004, but budgeted $7,355,387. Our Maternal & Child Health investment for FY2004 was $47,900,499, including a $9,313,074 of state funds, not including program income and private funds.

The state match exceeds the three for four-requirement for the expended FY2004 funds and the proposed FY2006 funds, including the carry forward. The maintenance of effort amount for FY2004 and for proposed FY2006 exceeds the FY89 level of effort of $1,875,000. Our commitment to Kids Net, Family Outreach/ Home Visiting and School Based Health Centers are some of the ways that RI commits state funds to maintain its match with HRSA, Title V. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting, oversight) that fall within the purview of administration. This is consistent with a legal opinion on the subject obtained by the Association of Maternal and Child Health Programs.

Rhode Island proposes to expend approximately $4,436,233 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend $4,248,380 on population based services an increase from prior years reflecting our investment in Childhood Immunization as well as newborn screening. There is decrease in direct medical services from the prior year mostly from transference of EI funds to DHS. Budget for Enabling Services equals $1,369,921, which is an increase to prior years investments.

The Division plans to allocate its FY2006 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a program chief or manager, as well as monitored by fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division administrator prior to reimbursement //2006//.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.